

Volume 39, Number 9  
Pages 911-1022  
May 1, 2014

SALUS POPULI SUPREMA LEX ESTO

*"The welfare of the people shall be the supreme law."*



JASON KANDER  
SECRETARY OF STATE

MISSOURI  
REGISTER

The *Missouri Register* is an official publication of the state of Missouri, under the authority granted to the secretary of state by sections 536.015, RSMo Supp. 2013 and 536.033, RSMo 2000. Reproduction of rules is allowed; however, no reproduction shall bear the name *Missouri Register* or "official" without the express permission of the secretary of state.

The *Missouri Register* is published semi-monthly by

**SECRETARY OF STATE**

**JASON KANDER**

Administrative Rules Division

James C. Kirkpatrick State Information Center  
600 W. Main  
Jefferson City, MO 65101  
(573) 751-4015

DIRECTOR

WAYLENE W. HILES

•

MANAGING EDITOR

CURTIS W. TREAT

•

EDITOR

AMANDA MCKAY

•

ASSISTANT EDITOR

VONNE KILBOURN

•

ASSISTANT EDITOR

MARTY SPANN

•

PUBLICATION TECHNICIAN

JACQUELINE D. WHITE

•

ADMINISTRATIVE ASSISTANT

ALISHA DUDENHOEFFER

ISSN 0149-2942, USPS 320-630; periodical postage paid at Jefferson City, MO  
Subscription fee: \$56.00 per year

POSTMASTER: Send change of address notices and undelivered copies to:

**MISSOURI REGISTER**

Office of the Secretary of State

Administrative Rules Division

PO Box 1767

Jefferson City, MO 65102

The *Missouri Register* and *Code of State Regulations* (CSR) are now available on the Internet. The Register address is <http://www.sos.mo.gov/adrules/moreg/moreg.asp> and the CSR is <http://www.sos.mo.gov/adrules/csr/csr.asp>. These websites contain rulemakings and regulations as they appear in the Registers and CSR. These websites do not contain the official copies of the Registers and CSR. The official copies remain the paper copies published by the Office of the Secretary of State pursuant to sections 536.015 and 536.031, RSMo Supp. 2013. While every attempt has been made to ensure accuracy and reliability, the Registers and CSR are presented, to the greatest extent practicable as they appear in the official publications. The Administrative Rules Division may be contacted by email at [rules@sos.mo.gov](mailto:rules@sos.mo.gov).

The secretary of state's office makes every effort to provide program accessibility to all citizens without regard to disability. If you desire this publication in alternate form because of a disability, please contact the Division of Administrative Rules, PO Box 1767, Jefferson City, MO 65102, (573) 751-4015. Hearing impaired citizens should contact the director through Missouri relay, (800) 735-2966.



## IN THIS ISSUE:

### EMERGENCY RULES

#### Department of Economic Development

Division of Business and Community Services . . . . . 915

### EXECUTIVE ORDERS . . . . . 956

### ORDERS OF RULEMAKING

#### Department of Elementary and Secondary Education

Division of Learning Services . . . . . 960

#### Department of Public Safety

Missouri Gaming Commission . . . . . 960

#### Department of Social Services

Family Support Division . . . . . 961

MO HealthNet Division . . . . . 964

#### Missouri Consolidated Health Care Plan

Health Care Plan . . . . . 964

### CONTRACTOR DEBARMENT LIST . . . . . 1004

### DISSOLUTIONS . . . . . 1005

### SOURCE GUIDES

RULE CHANGES SINCE UPDATE . . . . . 1007

EMERGENCY RULES IN EFFECT . . . . . 1013

EXECUTIVE ORDERS . . . . . 1015

REGISTER INDEX . . . . . 1016

Register Filing Deadlines	Register Publication Date	Code Publication Date	Code Effective Date
January 2, 2014 January 15, 2014	<b>February 3, 2014</b> <b>February 18, 2014</b>	February 28, 2014 February 28, 2014	March 30, 2014 March 30, 2014
February 3, 2014 February 18, 2014	<b>March 3, 2014</b> <b>March 17, 2014</b>	March 31, 2014 March 31, 2014	April 30, 2014 April 30, 2014
March 3, 2014 March 17, 2014	<b>April 1, 2014</b> <b>April 15, 2014</b>	April 30, 2014 April 30, 2014	May 30, 2014 May 30, 2014
April 1, 2014 April 15, 2014	<b>May 1, 2014</b> <b>May 15, 2014</b>	May 31, 2014 May 31, 2014	June 30, 2014 June 30, 2014
May 1, 2014 May 15, 2014	<b>June 2, 2014</b> <b>June 16, 2014</b>	June 30, 2014 June 30, 2014	July 30, 2014 July 30, 2014
June 2, 2014 June 16, 2014	<b>July 1, 2014</b> <b>July 15, 2014</b>	July 31, 2014 July 31, 2014	August 30, 2014 August 30, 2014
July 1, 2014 July 15, 2014	<b>August 1, 2014</b> <b>August 15, 2014</b>	August 31, 2014 August 31, 2014	September 30, 2014 September 30, 2014
August 1, 2014 August 15, 2014	<b>September 2, 2014</b> <b>September 15, 2014</b>	September 30, 2014 September 30, 2014	October 30, 2014 October 30, 2014
September 2, 2014 September 15, 2014	<b>October 1, 2014</b> <b>October 15, 2014</b>	October 31, 2014 October 31, 2014	November 30, 2014 November 30, 2014

Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at <http://www.sos.mo.gov/adrules/pubsched.asp>

# Missouri Participating Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Documents Law (section 181.100, RSMo Supp. 2013), are available in the listed participating libraries, as selected by the Missouri State Library:

Jefferson County Library PO Box 1486, 3021 High Ridge High Ridge, MO 63049-1486 (314) 677-8689	Learning Resources Center Mineral Area College PO Box 1000 Park Hills, MO 63601-1000 (573) 431-4593	Hearnes Learning Resources Ctr. Missouri Western State University 4525 Downs Drive St. Joseph, MO 64507-2294 (816) 271-5802	Library Missouri University of Science and Technology 1870 Miner Circle Rolla, MO 65409-0060 (573) 341-4007
Jefferson College Library 1000 Viking Drive Hillsboro, MO 63050-2441 (314) 789-3951 ext. 160	Cape Girardeau Public Library 711 N. Clark Cape Girardeau, MO 63701-4400 (573) 334-5279	Library North Central Missouri College PO Box 111, 1301 Main Street Trenton, MO 64683-0107 (660) 359-3948 ext. 325	Lebanon-Laclede County Library 915 S. Jefferson Ave. Lebanon, MO 65536-3017 (417) 532-2148
St. Louis Public Library 1301 Olive St. St. Louis, MO 63103-2389 (314) 539-0376	Kent Library Southeast Missouri State University One University Plaza Cape Girardeau, MO 63701-4799 (573) 651-2757	Spiva Library Missouri Southern State University 3950 East Newman Road Joplin, MO 64801-1595 (417) 625-9342	University Library Southwest Baptist University 1600 University Ave. Bolivar, MO 65613-2597 (417) 328-1631
St. Louis University Law Library 3700 Lindell Blvd. St. Louis, MO 63108-3478 (314) 977-2742	Riverside Regional Library PO Box 389, 1997 E. Jackson Blvd. Jackson, MO 63755-0389 (573) 243-8141	Missouri State Library 600 West Main, PO Box 387 Jefferson City, MO 65102-0387 (573) 751-3615	Barry-Lawrence Regional Library 213 6th St. Monett, MO 65708-2147 (417) 235-6646
Eden/Webster Library Eden Theological Seminary/ Webster University 475 East Lockwood Ave. St. Louis, MO 63119-3192 (314) 961-2660 ext. 7812	Rutland Library Three Rivers Community College 2080 Three Rivers Blvd. Poplar Bluff, MO 63901-2393 (573) 840-9656	Missouri State Archives 600 West Main, PO Box 778 Jefferson City, MO 65102-0778 (573) 526-6711	Lyons Memorial Library College of the Ozarks General Delivery Point Lookout, MO 65726-9999 (417) 334-6411 ext. 3551
Thomas Jefferson Library University of Missouri-St. Louis 8001 Natural Bridge Road St. Louis, MO 63121-4499 (314) 516-5084	James C. Kirkpatrick Library University of Central Missouri 142 Edwards Library Warrensburg, MO 64093-5020 (660) 543-4149	Elmer Ellis Library University of Missouri-Columbia 106 B Ellis Library Columbia, MO 65211-5149 (573) 882-0748	Garnett Library Missouri State University—West Plains 304 Cleveland West Plains, MO 65775-3414 (417) 255-7945
Washington University Law Library Washington University Campus Box 1171, Mudd Bldg., One Brookings Dr. St. Louis, MO 63130-4899 (314) 935-6443	Kansas City Public Library 14 West 10th Street Kansas City, MO 64105 (816) 701-3546	Library State Historical Society of Missouri 1020 Lowry St. Columbia, MO 65211-7298 (573) 882-9369	Springfield-Greene County Library 4653 S. Campbell Springfield, MO 65801-0760 (417) 874-8110
St. Louis County Library 1640 S. Lindbergh Blvd. St. Louis, MO 63131-3598 (314) 994-3300 ext. 247	Law Library University of Missouri-Kansas City 5100 Rockhill Road Kansas City, MO 64110-2499 (816) 235-2438	Daniel Boone Regional Library PO Box 1267, 100 West Broadway Columbia, MO 65205-1267 (573) 443-3161 ext. 359	Meyer Library Missouri State University PO Box 175, 901 S. National Springfield, MO 65804-0095 (417) 836-4533
Library Maryville University 13550 Conway Road St. Louis, MO 63141-7232 (314) 529-9494	Miller Nichols Library University of Missouri-Kansas City 5100 Rockhill Road Kansas City, MO 64110-2499 (816) 235-2438	School of Law University of Missouri-Columbia 224 Hulston Hall Columbia, MO 65211-0001 (573) 882-1125	
Pickler Memorial Library Truman State University 100 E. Normal Kirksville, MO 63501-4221 (660) 785-7416	B.D. Owens Library Northwest Missouri State University 800 University Drive Maryville, MO 64468-6001 (660) 562-1841	Smiley Memorial Library Central Methodist University 411 Central Methodist Square Fayette, MO 65248-1198 (660) 248-6279	
	St. Joseph Public Library 927 Felix Street St. Joseph, MO 64501-2799 (816) 232-8151		

## HOW TO CITE RULES AND RSMo

**RULES**—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 28, *Missouri Register*, page 27. The approved short form of citation is 28 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

**RSMo**—The most recent version of the statute containing the section number and the date.

**R**ules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

**R**ules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

**A**ll emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

## Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT

### Division 85—Division of Business and Community Services

#### Chapter 8—Amateur Sporting Contribution Tax Credit Program

#### EMERGENCY RULE

##### 4 CSR 85-8.011 Definitions

**PURPOSE:** *This rule explains the meaning of terms used in connection to the Amateur Sporting Contribution Tax Credit Program.*

**EMERGENCY STATEMENT:** *Because section 67.3005, RSMo, caused the Amateur Sporting Contribution Tax Credit Program to become effective as of August 28, 2013, this emergency rule is required by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be*

*enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) As used in 4 CSR 85-8.011 through 4 CSR 85-8.021, the following words shall mean:

(A) Administrative hold: Applications that would otherwise gain approval but for insufficient cap space are not approved but are held until such time as cap space becomes available or the program sunsets;

(B) Applicant: Certified sponsor or local organizing committee;

(C) Application: All of the following, submitted together to the department:

1. A Department of Economic Development (DED) Form Sporting Contribution Tax Credit Program (SCTCP) Application, included herein;

2. Proof of payment showing that the applicant received an eligible donation from the contributor; and

3. Payment for the issuance fee to the department, the issuance fee payment must be in the form of a check payable to the state of Missouri;

(D) Approved: An application that the department has determined has met all requirements necessary for the issuance of tax credits;

(E) Certified sponsor: A nonprofit organization which is an active member of the National Association of Sports Commissions;

(F) Contributor: Any one (1) of the following:

1. A taxpayer, as that phrase is used in section 67.3000.1(16), RSMo;

2. A person, firm, partner in a firm, corporation, or a shareholder in an S corporation doing business in the state of Missouri and subject to the state income tax imposed under Chapter 143, RSMo;

3. A corporation subject to the annual corporation franchise tax imposed under Chapter 147, RSMo;

4. An insurance company paying an annual tax on its gross premium receipts in this state;

5. Any other financial institution paying taxes to the state of Missouri or any political subdivision of this state under Chapter 148, RSMo; or

6. An individual subject to the state income tax imposed under Chapter 143, RSMo; any charitable organization which is exempt from federal income tax and whose Missouri unrelated business taxable income, if any, would be subject to the state income tax imposed under Chapter 143, RSMo;

(G) Cap space: An amount equal to ten (10) million dollars less all tax credits issued under the program in a given fiscal year;

(H) Department: The Missouri Department of Economic Development;

(I) Denial: An application is denied when it is deemed by the department to be ineligible for tax credits;

(J) Eligible donation: Donations received by a certified sponsor or local organizing committee, from a contributor that may include cash, publicly traded stocks and bonds, and real estate that is valued with an independent third party appraisal submitted to the department

along with the application. Eligible donations must be used solely to provide funding to attract sporting events to the state and cannot be conditional. There can be no right on the part of the contributor to request return of an eligible donation under any circumstances;

(K) Fiscal year: The state fiscal year, running from July through June;

(L) Issuance fee: An amount payable to the state of Missouri that is equal to one-half (1/2) of the value of the eligible donation;

(M) Local organizing committee: A nonprofit corporation or its successor in interest that—

1. Has been authorized by one (1) or more certified sponsors, endorsing municipalities, or endorsing counties, acting individually or collectively, to pursue an application and bid on its or the applicant's behalf to a site selection organization for selection as the host of one (1) or more sporting events; or

2. With the authorization of one (1) or more certified sponsors, endorsing municipalities, or endorsing counties, acting individually or collectively, executes an agreement with a site selection organization regarding a bid to host one (1) or more sporting events;

(N) Program: The Sporting Contribution Tax Credit Program found in section 67.3005, RSMo;

(O) Program sunset: The date on which the program is to end pursuant to the Missouri Sunset Act found in section 23.253, RSMo;

(P) Proof of payment: A bank statement, canceled check, or other documentation of the eligible donation showing the transfer of property from the contributor to the applicant;

(Q) Reactivation: Taking an application off of administrative hold status;

(R) Request for reactivation: Formally asking that an application be taken off of the administrative hold status;

(S) State: The state of Missouri;

(T) Tax credits: A credit or credits issued by the department against the tax otherwise due under Chapters 143 or 148, RSMo, excluding withholding tax imposed under sections 143.191 to 143.265, RSMo, tax credits issued under this program may be assigned, transferred, sold, or otherwise conveyed, and the new owner of the tax credit shall have the same rights in the credit as the taxpayer; and

(U) Taxpayer: Any one (1) of the following:

1. A person, firm, partner in a firm, corporation, or a shareholder in an S corporation doing business in the state of Missouri and subject to the state income tax imposed under Chapter 143, RSMo;

2. A corporation subject to the annual corporation franchise tax imposed under Chapter 147, RSMo;

3. An insurance company paying an annual tax on its gross premium receipts in this state;

4. Any other financial institution paying taxes to the state of Missouri or any political subdivision of this state under Chapter 148, RSMo; or

5. An individual subject to the state income tax imposed under Chapter 143, RSMo; any charitable organization which is exempt from federal income tax and whose Missouri unrelated business taxable income, if any, would be subject to the state income tax imposed under Chapter 143, RSMo.



**DED Form SCTCP App**

LOG NUMBER (OFFICIAL USE ONLY)

**AMATEUR SPORTING CONTRIBUTION TAX  
CREDIT PROGRAM PROJECT PROPOSAL FORM**

NAME OF INDIVIDUAL OR ENTITY			
<b>IF APPLICANT IS A BUSINESS ENTITY:</b>			
Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited		Corporation <input type="checkbox"/> Regular <input type="checkbox"/> Subchapter S <input type="checkbox"/> Not for Profit <input type="checkbox"/> Trust <input type="checkbox"/> LLC <input type="checkbox"/> Other (Specify):	
NAME OF AUTHORIZED COMPANY OFFICIAL		TITLE	
BUSINESS ADDRESS			
CITY/TOWN		STATE	ZIP CODE
TELEPHONE	FAX		
TAXPAYER IDENTIFICATION NUMBER			
NAICS CODE (See Definitions in Guidelines)	BUSINESS SIZE (Number of Employees Including Company Owners)		
EMAIL ADDRESS			
HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.			
<input type="checkbox"/> Applicant <input type="checkbox"/> Owner <input type="checkbox"/> Other (Consultant, etc.)			
NAME			
ADDRESS			
CITY/TOWN		STATE	ZIP CODE
TELEPHONE	EMAIL ADDRESS	FAX	
HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.			

IF TAXPAYER IS A BUSINESS ENTITY:				IF TAXPAYER IS AN INDIVIDUAL TAXPAYER:	
Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited <input type="checkbox"/> Other (specify) _____		Corporation <input type="checkbox"/> Regular <input type="checkbox"/> Subchapter S <input type="checkbox"/> Trust <input type="checkbox"/> LLC		<input type="checkbox"/> Property Owner <input type="checkbox"/> Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL		TITLE		MAILING ADDRESS	
BUSINESS ADDRESS				CITY/TOWN	
CITY/TOWN		STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE		FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)				SOCIAL SECURITY NUMBER	
MISSOURI TAXPAYER IDENTIFICATION NUMBER				MISSOURI TAXPAYER IDENTIFICATION NUMBER	
NAICS CODE (See Definitions in Guidelines)		BUSINESS SIZE (Number of Employees Including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS				EMAIL ADDRESS	
HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					

NUMBER OF JOBS CREATED AS A RESULT OF TAX CREDITS		
NEW CONSTRUCTION JOBS	NEW CONSTRUCTION JOBS	NEW CONSTRUCTION JOBS

ELIGIBLE DONATION	TAX CREDITS REQUESTED
IS THE APPLICANT (BUSINESS ENTITY) ENROLLED AND PARTICIPATING IN THE E-VERIFY PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Missouri statutes (Section 285.525-285.555, RSMo) require any business entity receiving a state-administered tax credit to participate in a federal work authorization program, which enables employers to electronically verify employment eligibility with respect to employees working in connection with the activities that qualify the applicant for this program.	
To access the E-Verify website, go to: <a href="https://e-verify.uscis.gov/enroll">https://e-verify.uscis.gov/enroll</a>	
PLEASE SUBMIT THE FOLLOWING ADDITIONAL DOCUMENTS:	
<input type="checkbox"/> Back-up documentation showing proof of the Eligible Donation.	
<input type="checkbox"/> A copy of the Memorandum of Understanding for the E-Verify Program	
<input type="checkbox"/> The Application Fee	
<input type="checkbox"/> Proof of Applicant Eligibility	



ARE THERE OTHER LOCAL, FEDERAL, STATE OF MISSOURI TAX CREDITS OR GRANTS BEING APPLIED TOWARD THIS PROJECT?

☐ YES ☐ NO

IF YES, WHICH FEDERAL OR STATE PROGRAM? (SPECIFY AMOUNT IN SPACE PROVIDED.)

☐ Missouri Housing Development Commission \$ \_\_\_\_\_

☐ Brownfield \$ \_\_\_\_\_

☐ Enterprise Zone \$ \_\_\_\_\_

☐ New Business Facility \$ \_\_\_\_\_

☐ Federal Historic Preservation \$ \_\_\_\_\_

☐ Neighborhood Assistance \$ \_\_\_\_\_

☐ Neighborhood Preservation \$ \_\_\_\_\_

☐ Youth Opportunity \$ \_\_\_\_\_

☐ Local Community Development Block Grant \$ \_\_\_\_\_

☐ Community Development Block Grant \$ \_\_\_\_\_

☐ Other (please specify program(s) and amount) \_\_\_\_\_

1. I certify that I am an authorized representative of the applicant and, as such, am authorized to make the statement of affirmation contained herein.
2. The information submitted by the applicant to DED in connection with this application are true and correct and such information is consistent with documents provided to lenders, other government programs, or investors. The applicant hereby authorizes DED to verify such information.
3. Neither the applicant, nor any individual with an ownership interest in the applicant:
  - a. Has committed a felony, is currently under indictment or charged with a felony, or is currently on parole or probation;
  - b. Is delinquent with respect to any non-protested federal, state or local taxes or fees;
  - c. Has filed, or is preparing to file, for bankruptcy, unless otherwise disclosed to DED; or
  - d. Has failed to fulfill any obligation under any other state or federal program, including a failure to pay as agreed any accrual upon which tax credits were issued.
4. I will inform DED, if at any time before project completion, there is any change to the certifications made in paragraphs 3(a) through 3(d) of this statement of affirmation.
5. The applicant, and any vendors the applicant will utilize to perform the work associated with the project, are registered and in good standing with the Missouri Secretary of State's Office.
6. The applicant agrees to comply with any and all agreements made pursuant to the project, upon which tax credits are issued.
7. I certify that the applicant does NOT knowingly employ any person who is an unauthorized alien and that the applicant has complied with federal law (8 U.S.C. § 1324a) requiring the examination of an appropriate document or documents to verify that each individual is not an unauthorized alien.
8. I certify that applicant is enrolled and will participate in a federal work authorization program as defined in Section 285.525(6), RSMo., with respect to employees working in connection with the activities that qualify applicant for this program. I certify that the applicant will maintain and, upon request, provide to DED documentation demonstrating applicant's participation in a federal work authorization program with respect to employees working in connection with the activities that qualify applicant for this program.
9. The applicant understands that, pursuant to section 285.530.5, RSMo, a general contractor or subcontractor of any tier shall not be liable under sections 285.525 to 285.550 when such general contractor or subcontractor contracts with its direct subcontractor who violates section 285.530.1, if the contract binding the contractor and subcontractor affirmatively states that the direct subcontractor is not knowingly in violation of section 285.530.1 and shall not henceforth be in such violation and the contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.
10. I understand that if the applicant is found to have employed an unauthorized alien, applicant may subject to penalties pursuant to Sections 135.815, 285.025, and 285.535, RSMo.

**11. I certify that (check the applicable box):**

☐ I have included a copy of the executed E-Verify Program for Employment Verification Memorandum of Understanding between the company/organization and the Department of Homeland Security, United States Citizenship and Immigration Services (DHS-USCIS) and Social Security Administration.

☐ I am not a business entity as defined in Section 285.525 (1) RSMo. Section 285.525(1) defines business entity as "any person or group of persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage or livelihood. The term "business entity" shall include but not be limited to self-employed individuals, partnerships, corporations, contractors, and subcontractors. The term "business entity" shall include any business entity that possesses a business permit, license, or tax certificate, issued by the state, any business entity that is exempt by law from obtaining such a business permit, any business entity that is operating unlawfully without such a business permit. The term "business entity" shall not include a self-employed individual with no employees or entities utilizing the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo."

**12. By submitting this application, I acknowledge that the applicant shall comply with Amateur Sporting Events Tax Credit Program requirements. I further acknowledge that the applicant's failure to comply with the Program requirements shall result in the return to DED of any remaining unexpended tax credit proceeds and repayment to DED the monetary value of any expended tax credit proceeds**

**13. I attest to having received the Eligible Donation described above from the Taxpayer listed above. I further attest that I shall only use the Eligible Donation to fund activities directly related to attracting a Sporting Event to the State of Missouri.**

**14. I shall submit to the Taxpayer, all information necessary for the Taxpayer to comply with the Tax Credit Accountability Act by no later than May 30th of any year during the Taxpayer's reporting period under the Tax Credit Accountability Act. I agree to be liable to the Taxpayer for any penalty imposed under the Tax Credit Accountability Act as a direct result of my failure to supply information to the Taxpayer.**

**15. I certify under penalties of perjury that the above statements, information contained in the application and attachments are complete, true, and correct to the best of my knowledge. I also realize that failure to disclose material information regarding the applicant, its owners, or any other pertinent facts may result in criminal prosecution.**

APPLICANT SIGNATURE	PRINT NAME	TITLE	DATE
NOTARY PUBLIC EMBOSSEER SEAL	On this _____ day of _____, 20____, appeared _____ to me personally known to be the person who executed the above certification, and acknowledges and states on his/her oath to me that he/she executed the same for the purpose therein stated.		
	STATE OF _____		COUNTY _____
	NOTARY PUBLIC NAME _____	MY COMMISSION EXPIRES _____	USE RUBBER STAMP IN AREA BELOW
	NOTARY PUBLIC SIGNATURE _____		

**APPLICATION INSTRUCTIONS:****1. APPLICANT INFORMATION:**

**Name:** Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

**Type of Entity:**

- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- **Special Note:** For entities with flow through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

**2. PROJECT CONTACT:**

**Applicant/Owner/Other:** Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

**3. TAXPAYER INFORMATION:**

Please contact the Taxpayer to obtain the relevant information.

**4. ECONOMIC ACTIVITY RESULTING FROM THE USE OF TAX CREDITS:**

**Anticipated Number of Jobs Created:** Enter the number of jobs expected to be created as a result of the Tax Credits; this number should include new construction, full time permanent, and part time permanent jobs.

**New Construction Jobs:** Construction-related jobs created as a result of the Tax Credits.

**Full-Time Permanent Jobs:** Full-time permanent jobs created as a result of the Tax Credits, which should not include full-time equivalent jobs made up of several part-time jobs.

**Part-Time Permanent Jobs:** Part-time permanent jobs created as a result of the Tax Credits.

**9. TOTAL NUMBER OF REQUESTED TAX CREDITS:**

**Eligible Donation:** List the Fair Market Value of the Eligible Donation at the time the Donation was made.

**Tax Credits Requested:** 50% of the Eligible Donation.

**10. PARTICIPATING IN THE E-VERIFY PROGRAM?**

Please indicate yes or no. Participation in the E-Verify Program is a prerequisite of receiving ASTCP tax credits.

**11. ADDITIONAL DOCUMENTS REQUIRED:**

**Back-up documentation:** The Applicant must provide documents demonstrating that a transfer of property occurred in order to make an Eligible Donation, and the Applicant must provide proof of the value of the Eligible Donation when applicable (see Eligible Donation in the Definitions Section).

**A copy of the Memorandum of Understanding for the E-Verify Program:** The Memorandum of Understanding must be properly executed by the Applicant.

**The Application Fee:** Provide a check payable to the State of Missouri in an amount equal to the value of the Tax Credits for which this Application is made.

**Proof of Applicant Eligibility:** Please provide back-up establishing that the Applicant is either a Certified Sponsor or a Local Organizing Committee.

**12. OTHER INCENTIVES USED:**

**Are there other State of Missouri tax credits being applied toward this project?** Select the appropriate box. If "Yes," please indicate which programs are applicable. If no other programs are being applied to the project, check "No."

**13. ASTCP – APPLICANT CERTIFICATION:**

**Must be signed and notarized.**

*AUTHORITY: section 67.3005, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the Missouri Register.*

**Title 4—DEPARTMENT OF ECONOMIC  
DEVELOPMENT**

**Division 85—Division of Business and Community  
Services**

**Chapter 8—Amateur Sporting Contribution Tax  
Credit Program**

**EMERGENCY RULE**

**4 CSR 85-8.021 Program Administration**

*PURPOSE: This rule explains the administration of the program cap for the Amateur Sporting Contribution Tax Credit Program.*

*EMERGENCY STATEMENT: Because section 67.3005, RSMo, caused the Amateur Sporting Contribution Tax Credit Program to become effective as of August 28, 2013, this emergency rule is required by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) If the applicant has submitted all required documents in an application accurately and completely, the contributor associated with an application shall be issued tax credits, so long as there is cap space available in the fiscal year in which an application is to be approved.

(2) The department will not exercise its authority to require an additional fee under section 620.1900, RSMo.

(3) Complete and accurate applications shall be allocated cap space in the order received. If two (2) or more complete and accurate applications are received on the same day, a lottery will be used to determine the order in which applications will be approved.

(4) If there is insufficient cap space available in a fiscal year for an otherwise valid application to be approved, the application will be

placed on administrative hold.

(A) Applications placed on administrative hold due to a lack of available cap space will not have their issuance fees processed when the applications are undergoing the approval process. Any issuance fee payment received by the department will be returned to the applicant.

(B) If cap space becomes available for an application placed on administrative hold prior to the program sunset, the application will be denied unless—

1. The applicant submits a request for reactivation within thirty (30) days following the date on which the department first sent official notification; and

2. The applicant submits a new issuance fee.

(C) Requests for reactivation will be processed in the order the underlying applications were received. If two (2) or more applications were received on the same day the requests for reactivation will be processed in the order established by a lottery.

(5) If there is only sufficient cap space available in a fiscal year for a portion of a valid application to be processed, the applicant must submit a new issuance fee to cover the portion of the award request that has sufficient cap space available. The remaining cap space will be placed on administrative hold and will be processed as described in sections (1) through (4) of this rule.

(6) All applications on administrative hold as of the date when the program sunsets will be denied.

*AUTHORITY: section 67.3005, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the Missouri Register.*

**Title 4—DEPARTMENT OF ECONOMIC  
DEVELOPMENT**

**Division 85—Division of Business and Community  
Services**

**Chapter 9—Amateur Sporting Tax Credit Program**

**EMERGENCY RULE**

**4 CSR 85-9.011 Definitions**

*PURPOSE: The purpose of this rule is to explain the meaning of terms used in connection with the Amateur Sporting Tax Credit Program.*

*EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively*

*pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) As used in 4 CSR 85-9.011 through 4 CSR 85-9.051, the following words shall mean:

(A) Account(s) receivable: A legally enforceable claim for payment against an applicant, payable within sixty (60) days following the sporting event;

(B) Active member: An organization located in the state of Missouri, which solicits and services sports events, sports organizations, and other types of sports-related activities in that community;

(C) Admission ticket: A ticket that is purchased for face value;

(D) Amateur athlete: An individual who participates in a sporting event as a competitor, and is not compensated for participating in that sporting event; or an Olympian. Examples include: Olympic athletes and collegiate athletes participating under NCAA sponsored events;

(E) Amateur organization: An interstate organization, dedicated to promoting, organizing, or administering sporting games, or competitions among amateur athletes, athletes competing in Olympic pre-qualifying competitions, or Olympians;

(F) Applicant or applicants: One (1) or more of the following acting individually or collectively:

1. Certified sponsors;
2. Endorsing counties;
3. Endorsing municipalities;
4. Local organizing committees; or
5. Related parties to another applicant;

(G) Certified sponsor or certified sponsors: One (1) or more non-profit organizations which are active members of the National Association of Sports Commissions;

(H) Competitive bidding process: The selection system used by a site selection organization to choose the location of a sporting event. For a bidding process to be competitive, the competition must include at least one (1) site located outside of Missouri, and the sporting event cannot be one (1) whose history would typically place it in Missouri;

(I) Construction: Any activity directly or indirectly related to the building of new improvements on real property;

(J) DED: The Missouri Department of Economic Development;

(K) Department: The Missouri Department of Economic Development;

(L) *De Minimis* ticket price: A ticket sold for less than five dollars (\$5);

(M) Director: The director of the Department of Revenue;

(N) DOR: The Department of Revenue;

(O) Eligible costs: All costs, except ineligible costs, that are—

1. Necessary for conducting a sporting event;
2. Related to the preparations necessary for conducting a sporting event;

3. The pledged obligations to a site selection organization as evidenced by a support contract for a sporting event; and

4. Costs that are associated with retrofitting a facility if necessary to accommodate the specific approved sporting event;

(P) End of a sporting event: A sporting event shall be deemed to end upon the conclusion of the sporting event; or upon the last sporting event if there are multiple sporting events being held over several days;

(Q) Endorsing county: An endorsing municipality that is also a

county;

(R) Endorsing municipality or municipalities: Any city, town, incorporated village, or county that contains a site selected by a site selection organization for one (1) or more sporting events;

(S) Event notification period: A period starting no more than sixty (60) days prior to the start of a sporting event and ending no less than thirty (30) days prior to the start of a sporting event. If the sporting event is a series of sporting events covered under a single support contract, then the date of the first sporting event shall serve as the start of all the sporting events under that support contract;

(T) Face value: The sales price for a ticket that is sold at the amount printed on the face of the ticket (or disclosed in a comparable fashion in the case of an online purchase), provided that the face value is not for a *de minimis* ticket price, and the ticket is sold in the primary market;

(U) Ineligible expense: Any expense related to—

1. Construction;
2. Rehabilitation;
3. A payment to a related party;
4. A direct payment to a for-profit site selection organization; or
5. Any accrued cost, except that accounts receivable that are paid and submitted to the DED in the sixty (60) days following the submission of the Certification of Costs, shall be treated as eligible;

(V) Invoice: A descriptive list of goods and services provided, listing the sum due to be paid;

(W) Joinder agreements: An agreement entered into by one (1) or more applicants, acting individually or collectively, and a site selection organization setting out representations and assurances by each applicant in connection with the selection of a site in Missouri for the location of a sporting event;

(X) Joinder undertaking: An agreement entered into by one (1) or more applicants, acting individually or collectively, and a site selection organization that each applicant will execute a joinder agreement in the event that the site selection organization selects a site in Missouri for a sporting event;

(Y) Local organizing committee: A nonprofit corporation or its successor in interest that—

1. Has been authorized by one (1) or more certified sponsors, endorsing municipalities, or endorsing counties, acting individually or collectively, to pursue an application and bid on its or the applicant's behalf to a site selection organization regarding a bid to host one (1) or more sporting events; or

2. With the authorization of one (1) or more certified sponsors, endorsing municipalities, or endorsing counties, acting individually or collectively, executes an agreement with a site selection organization regarding a bid to host one (1) or more sporting events;

(Z) Major regional, national, and international sports organizations: An interstate organization, dedicated to promoting, organizing, or administering sporting games, or competitions among amateur athletes;

(AA) Necessary for conducting or necessary for the conduct of: Costs or preparations shall be deemed necessary, only if the sporting event could not occur without the cost in question;

(BB) Pledged obligation: All reasonable expense that must be undertaken by an applicant, pursuant to the support contract, as a condition of hosting the sporting event;

(CC) Proof of payment: Proof of payment must be indicated with a document showing that costs were incurred by the applicant, and that funds were transferred to the payee. Proof of payment documentation may include, but is not limited to, the following:

1. A bank or credit card statement showing the transfer of funds to the payee;

2. A canceled check from a bank;

3. A title company statement showing the transfer of funds from the title company to the payee. Documentation must also be provided showing the transfer of funds from the applicant to the title company; or

4. Other documentation acceptable to the department;

(DD) Rehabilitation: The repair, renovation, restoration, or reconstruction of a building.

(EE) Related party: Any party that would be deemed a related party under IRC section 267(b) and its associated regulations;

(FF) Retrofitting: The costs (hard and soft) related to modifying the facility that is directly necessary and required to facilitate the specific sporting event. Retrofit costs are designated to be project specific and may be temporary or permanent in nature;

(GG) Site selection organization: The National Collegiate Athletic Association (NCAA); an NCAA member conference, university, or institution; the National Association of Intercollegiate Athletics (NAIA); the United States Olympic Committee (USOC); a national governing body (NGB) or international federation of a sport recognized by the USOC; the United States Golf Association (USGA); the United States Tennis Association (USTA); the Amateur Softball Association of America (ASA); other major regional, national, and international sports associations, and amateur organizations that promote, organize, or administer sporting games, or competitions; or other major regional, national, and international organizations that promote or organize sporting events;

(HH) Sources and uses: A document prepared by the applicant showing the available funds that will be used to conduct the sporting event, along with all projected expenses associated with the sporting event;

(II) Sporting event: An amateur or Olympic sporting event that is competitively bid (at least one (1) of which was a bid for a location outside of Missouri) and is awarded by a site selection organization. A sporting event may include several sporting events provided those sporting events are all covered under a single support contract;

(JJ) Support contract: An event award notification, joinder undertaking, joinder agreement, or contract executed by an applicant and a site selection organization as submitted with the project proposal. All pledged obligations must be specifically listed within the support contract itself. If the support contract incorporates additional documents by reference, those additional documents must be submitted as part of the support contract in order to be considered by the DED;

(KK) Tax credit: A credit issued by the Department of Economic Development against the tax otherwise due under Chapters 143 or 148, RSMo, excluding withholding tax imposed under sections 143.191 to 143.265, RSMo.

*AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register.*

## **Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT**

### **Division 85—Division of Business and Community Services**

#### **Chapter 9—Amateur Sporting Tax Credit Program**

#### **EMERGENCY RULE**

#### **4 CSR 85-9.021 Application Process**

*PURPOSE: The purpose of this rule is to explain the application process for the Amateur Sporting Tax Credit Program.*

*EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had*

*arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) The application process will be comprised of the following steps:

(A) In the project proposal step the department will—

1. Determine if the project meets the statutory criteria for eligibility;

2. Evaluate the economic impact of the sporting event upon the state of Missouri. The evaluation of economic impact will determine if the sporting event has a positive economic impact upon the state using one (1) of two (2) methods—

A. Require proof of a positive economic impact. Project proposals which include major regional, national, and international sports associations, amateur organizations, or major regional, national, and international organizations must provide data which will be analyzed by the department to find if the sporting event has a positive return of general revenue proceeds to the state in the same state fiscal year as the event. That analysis shall be performed by the department as a benefit cost analysis using data provided by the applicant in the project proposal; or

B. Meet a presumption of a positive economic impact. The department will presume that the project generates a positive economic impact if the project proposal uses any of the following site selection organizations:

(I) The National Collegiate Athletic Association (NCAA);

(II) An NCAA member conference, university, or institution;

(III) The National Association of Intercollegiate Athletics (NAIA);

(IV) The United States Olympic Committee (USOC);

(V) A national governing body (NGB) or international federation of a sport recognized by the USOC;

(VI) The United States Golf Association (USGA);

(VII) The United States Tennis Association (USTA); or

(VIII) The Amateur Softball Association of America (ASA).

3. Tax credits will be reserved for a project proposal if that project proposal meets the statutory criteria for eligibility, and the project proposal is determined to have a positive economic impact;

4. A project proposal will be denied if that project proposal either fails to meet the statutory criteria for eligibility, or if it is determined that the sporting event does not have a positive economic impact upon the state. Applicants will be informed of a denied project proposal by the department in writing;

(B) The applicant submits its support contract for department review.

1. The department will review a support contract only—

A. After reserving tax credits as part of the project proposal; or



B. In conjunction with a project proposal.

2. The department review of a support contract will include a determination of statutory compliance.

3. A project, with tax credits reserved, will be authorized to receive tax credits after a support contract is deemed to be in statutory compliance.

4. The support contract need not be made available for Department of Economic Development (DED) review prior to submission of the event notification, or prior to the sporting event, but in no event can approval or issuance of tax credits be made prior to receipt of an executed support contract;

(C) The event notification step in which the applicant notifies the department of an upcoming sporting event;

1. The event notification must be submitted to the department no less than thirty (30) days, and no more than sixty (60) days prior to the sporting event;

(D) The sporting event takes place;

(E) The applicant submits a cost certification in which the department determines eligibility and the potential amount of any tax credit award;

1. The cost certification must be submitted no later than thirty (30) days following the end of the sporting event or the project is denied;

2. The department and the director may determine the total number of tickets sold at face value for a sporting event within seven (7) days following the end of the sporting event;

A. If the department and the director do not determine the total number of tickets sold at face value for a sporting event, the department shall determine the number of admissions tickets sold to the event through evidence submitted by the applicant with the cost certification; and

(F) No later than sixty (60) days immediately following the receipt of the cost certification, the DED will issue tax credits equal to the lesser of one hundred percent (100%) of the eligible costs incurred by the applicant, or five dollars (\$5) for each admission ticket sold to the sporting event.

*AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the Missouri Register.*

## **Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT**

### **Division 85—Division of Business and Community Services**

#### **Chapter 9—Amateur Sporting Tax Credit Program**

#### **EMERGENCY RULE**

##### **4 CSR 85-9.031 Project Proposal**

*PURPOSE: The purpose of this rule is to explain the requirements for submitting and processing a project proposal.*

*EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering*

*the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) The following will be included as part of the project proposal:

(A) The Project Proposal Form, included herein;

(B) Identification of a presumed economic impact or a proven economic impact;

(C) The Memorandum of Understanding for the E-Verify Program; and

(D) A draft copy of the support contract, if available.

(2) The department reserves the right to make reasonable request for additional documentation in order to approve or deny a Project Proposal Form.

(3) A project proposal must meet the following statutory criteria in order for the project to be reserved tax credits:

(A) There must be cap space available. The department is limited to issuing only three (3) million dollars in tax credits in a given state fiscal year. Should the Department of Economic Development (DED) have reached the cap for a given year, any remaining applications will be placed on administrative hold until the earlier of—

1. A date upon which the support contract is awarded to another city, at which point the application will be denied;

2. A date upon which there is cap space available due to other denials in the fiscal year covered by the application, at which point cap space will be reserved for the applicant; or

3. Until a date ninety (90) days following the end of the sporting event, at which point the project will be denied;

(B) A project will be denied, even if it had been previously approved, when it becomes apparent that the sporting event will not be held as indicated in the project proposal. Denied projects shall have their reserved cap space allotted to other sporting events;

(C) The applicant and site selection organizations must be valid and fit within the appropriate definitions provided under 4 CSR 85-9.011;

(D) No site for a sporting event may have been chosen prior to December 1, 2012;

(E) Completed project proposals will be reviewed in the order received.

1. Projects will be given a reservation of tax credits in the order those projects complete their review.

2. In the event two (2) or more project proposals are received on the same day, and there is insufficient cap space available, a lottery will be used to determine the order of receipt.

3. Completed project proposals received prior to April 11, 2014 will also be reviewed in the order received, but no reservation of cap space will be made prior to April 11, 2014;

(F) No support contract will be certified unless the site selection organization has chosen to use a location in Missouri during a competitive bidding process in which at least one (1) competitive bid came from out of state; and

(G) No project proposal will result in a reservation of tax credits after August 28, 2019.

(4) A project proposal must also demonstrate a positive economic impact in order for the project to be reserved tax credit.

(A) Demonstrate proof of a positive economic impact. Project proposals which include major regional, national, and international sports associations, amateur organizations, or major regional, national, and international organizations must provide data which will be analyzed by the department to find if the sporting event has a positive return of general revenue proceeds to the state in the same state fiscal year as the event. That analysis shall be performed by the department as a benefit cost analysis using data provided by the applicant in the project proposal; or

(B) A presumption of a positive economic impact. The department will presume that the project generates a positive economic impact if the project proposal uses any of the following site selection organizations:

1. The National Collegiate Athletic Association (NCAA);
2. An NCAA member conference, university, or institution;
3. The National Association of Intercollegiate Athletics (NAIA);
4. The United States Olympic Committee (USOC);
5. A national governing body (NGB) or international federation of a sport recognized by the USOC;
6. The United States Golf Association (USGA);
7. The United States Tennis Association (USTA); or
8. The Amateur Softball Association of America (ASA).



## ASTCP PROJECT PROPOSAL

LOG NUMBER (OFFICIAL USE ONLY)

### AMATEUR SPORTING TAX CREDIT PROGRAM PROJECT PROPOSAL FORM

<b>NAME OF INDIVIDUAL OR ENTITY</b>					
<b>IF APPLICANT IS A BUSINESS ENTITY:</b>			<b>IF APPLICANT IS AN INDIVIDUAL TAXPAYER:</b>		
Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited		Corporation <input type="checkbox"/> Regular <input type="checkbox"/> Subchapter S <input type="checkbox"/> Trust <input type="checkbox"/> LLC		<input type="checkbox"/> Property Owner <input type="checkbox"/> Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL		TITLE		MAILING ADDRESS	
BUSINESS ADDRESS			CITY/TOWN		
CITY/TOWN		STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE		FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)			SOCIAL SECURITY NUMBER		
NAICS CODE (See Definitions in Guidelines)		BUSINESS SIZE (Number of Employees Including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS			EMAIL ADDRESS		
HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					
<input type="checkbox"/> Applicant <input type="checkbox"/> Owner <input type="checkbox"/> Other (Consultant, etc.)					
NAME					
ADDRESS					
CITY/TOWN			STATE	ZIP CODE	
TELEPHONE		EMAIL ADDRESS		FAX	
HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					

TYPE OF EVENT		
EVENT ADDRESS		
CITY/TOWN	STATE	ZIP CODE
COUNTY		
EVENT DATE (Include Beginning Date and Ending Date)		
<p><input type="checkbox"/> <b>Presumed Economic Impact – Certified Sponsor is (or will be):</b> (check one and provide name)</p> <p> <input type="checkbox"/> NCAA    <input type="checkbox"/> An NCAA Member Conference, University, or Institution    <input type="checkbox"/> NAIA    <input type="checkbox"/> USOC  <input type="checkbox"/> NGB, or International Federation of Sport as Recognized by the USOC    <input type="checkbox"/> USGA    <input type="checkbox"/> USTA    <input type="checkbox"/> ASA </p> <p><i>IF ANY BOX IS CHECKED UNDER PRESUMED ECONOMIC IMPACT, PROCEED TO QUESTION #11</i></p>		
<p><input type="checkbox"/> <b>Proven Economic Impact – Certified Sponsor is (or will be):</b> (check one and provide name)</p> <p> <input type="checkbox"/> Major Regional, National, and International Sports Association    <input type="checkbox"/> Amateur Organization    <input type="checkbox"/> Major Regional, National, and International Organization </p> <p><i>IF ANY BOX IS CHECKED UNDER PROVEN ECONOMIC BENEFIT, PROCEED TO QUESTION #5</i></p>		
<p><b>Proven Economic Impact Category Applicants Only: Questions 5 – 10 provides information necessary to analyze the economic impact and cost benefit of the Sporting Event proposal for Applicants whose events do not fall under the Presumed Economic Impact category. The information includes costs that may or may not be tax credit eligible, but are designed to provide a complete depiction of the expenditures and activities that cause economic impact in the State. Please attach any documentation or historical information that may support your estimates and responses.</b></p>		
DATES OF VENUE PREPARATION		
TOTAL ESTIMATED COSTS OF VENUE PREPARATION (To the extent feasible, please break out the total costs into the relevant categories provided below)	TOTAL AMOUNT	
MAINTENANCE COSTS	AMOUNT	
CONSTRUCTION COSTS	AMOUNT	
RENTAL SERVICES	AMOUNT	
PROFESSIONAL SERVICES (LOCAL ADVERTISING)	AMOUNT	
PROFESSIONAL SERVICES (LOCAL LEGAL COSTS)	AMOUNT	
PROFESSIONAL SERVICES (LOCAL FINANCIAL COSTS)	AMOUNT	
PROFESSIONAL SERVICES (OTHER)	AMOUNT	
OTHER	AMOUNT	
OTHER	AMOUNT	

<b>TOTAL ESTIMATED EVENT COSTS (To the extent feasible, please break out the total costs into the relevant categories provided below)</b>		<b>TOTAL AMOUNT</b>
<b>SECURITY</b>		<b>AMOUNT</b>
<b>RENTAL SERVICES (TYPE)</b>		<b>AMOUNT</b>
<b>RENTAL SERVICES (TYPE)</b>		<b>AMOUNT</b>
<b>PARKING</b>		<b>AMOUNT</b>
<b>OTHER</b>		<b>AMOUNT</b>
<b>OTHER</b>		<b>AMOUNT</b>
<b>EXPECTED ATTENDANCE</b>		<b>ESTIMATED LOCAL ATTENDEES</b>
<b>ESTIMATED OUT-OF-STATE ATTENDEES</b>		<b>PROJECTED AVERAGE TICKET SALES PRICE</b>
<b>ESTIMATED TICKETS SOLD AT FACE VALUE</b>		
<b>NUMBER OF JOBS CREATED AS A RESULT OF TAX CREDITS</b>		<b>NEW CONSTRUCTION JOBS</b>

<b>FOOD AND BEVERAGE</b>		<b>AMOUNT</b>
<b>MERCHANDISE</b>		<b>AMOUNT</b>
<b>OTHER</b>		<b>AMOUNT</b>
<b>TOTAL</b>		<b>AMOUNT</b>
<b>RESTAURANTS</b>		<b>AMOUNT</b>
<b>HOTELS OR LOGING</b>		<b>AMOUNT</b>
<b>TRANSPORTATION (CAR RENTALS, GAS, ETC)</b>		<b>AMOUNT</b>
<b>OTHER ENTERTAINMENT</b>		<b>AMOUNT</b>
<b>OTHER</b>		<b>AMOUNT</b>
<b>TOTAL</b>		<b>AMOUNT</b>
<b>ELIGIBLE COSTS</b>		<b>AMOUNT</b>
<b>ESTIMATED TICKETS SOLD AT FACE VALUE (SECTION 6 ABOVE)</b>	<b>NUMBER OF TICKETS MULTIPLIED BY \$5</b>	<b>AMOUNT</b>
<b>MAXIMUM TAX CREDITS</b>		<b>AMOUNT</b>

IS THE APPLICANT (BUSINESS ENTITY) ENROLLED AND PARTICIPATING IN THE E-VERIFY PROGRAM?

☐ YES ☐ NO

Missouri statutes (Section 285.525-285.555, RSMo) require any business entity receiving a state-administered tax credit to participate in a federal work authorization program, which enables employers to electronically verify employment eligibility with respect to employees working in connection with the activities that qualify the applicant for this program.

To access the E-Verify website, go to: <https://e-verify.uscis.gov/enroll>

PLEASE SUBMIT THE FOLLOWING ADDITIONAL DOCUMENTS:

- ☐ A copy of the Support Contract for the Sporting Event, if available
- ☐ Back-up documentation showing how the estimates for Sections 4 – 8 were arrived at. This documentation could include historical figures from previous events, historical data regarding average sales, and studies and research on the economic impact of a sporting event on an area.
- ☐ A copy of the Memorandum of Understanding for the E-Verify Program

ARE THERE OTHER LOCAL, FEDERAL, STATE OF MISSOURI TAX CREDITS OR GRANTS BEING APPLIED TOWARD THIS PROJECT?

☐ YES ☐ NO

IF YES, WHICH FEDERAL OR STATE PROGRAM? (SPECIFY AMOUNT IN SPACE PROVIDED.)

- |   |   |
|---|---|
| <input type="checkbox"/> Missouri Housing Development Commission \$ _____ | <input type="checkbox"/> Brownfield \$ _____                        |
| <input type="checkbox"/> Enterprise Zone \$ _____                         | <input type="checkbox"/> New Business Facility \$ _____             |
| <input type="checkbox"/> Federal Historic Preservation \$ _____           | <input type="checkbox"/> Neighborhood Assistance \$ _____           |
| <input type="checkbox"/> Neighborhood Preservation \$ _____               | <input type="checkbox"/> Youth Opportunity \$ _____                 |
| <input type="checkbox"/> Local Community Development Block Grant \$ _____ | <input type="checkbox"/> Community Development Block Grant \$ _____ |
| <input type="checkbox"/> Sporting Contribution Tax Credit \$ _____        |   |
| <input type="checkbox"/> Other (please specify program(s) and amount)     |   |

- 1. I certify that I am an authorized representative of the applicant and, as such, am authorized to make the statement of affirmation contained herein.**
- 2. The information submitted by the applicant to DED in connection with this application is true and correct and such information is consistent with documents provided to lenders, other government programs, or investors. The applicant hereby authorizes DED to verify such information.**
- 3. Neither the applicant, nor any individual with an ownership interest in the applicant:**
  - a. Has committed a felony, is currently under indictment or charged with a felony, or is currently on parole or probation;**
  - b. Is delinquent with respect to any non-protested federal, state or local taxes or fees;**
  - c. Has filed, or is preparing to file, for bankruptcy, unless otherwise disclosed to DED; or**
  - d. Has failed to fulfill any obligation under any other state or federal program, including a failure to pay as agreed any accrual upon which tax credits were issued.**
- 4. I will inform DED, if at any time before project completion, there is any change to the certifications made in paragraphs 3(a) through 3(d) of this statement of affirmation.**
- 5. The applicant, and any vendors the applicant will utilize to perform the work associated with the project, are registered and in good standing with the Missouri Secretary of State's Office.**
- 6. The applicant agrees to comply with any and all agreements made pursuant to the project, upon which tax credits are issued.**
- 7. I certify that the applicant does NOT knowingly employ any person who is an unauthorized alien and that the applicant has complied with federal law (8 U.S.C. § 1324a) requiring the examination of an appropriate document or documents to verify that each individual is not an unauthorized alien.**
- 8. I certify that applicant is enrolled and will participate in a federal work authorization program as defined in Section 285.525(6), RSMo., with respect to employees working in connection with the activities that qualify applicant for this program. I certify that the applicant will maintain and, upon request, provide to DED documentation demonstrating applicant's participation in a federal work authorization program with respect to employees working in connection with the activities that qualify applicant for this program.**
- 9. The applicant understands that, pursuant to section 285.530.5, RSMo, a general contractor or subcontractor of any tier shall not be liable under sections 285.525 to 285.550 when such general contractor or subcontractor contracts with its direct subcontractor who violates section 285.530.1, if the contract binding the contractor and subcontractor affirmatively states that the direct subcontractor is not knowingly in violation of section 285.530.1 and shall not henceforth be in such violation and the contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.**
- 10. I understand that if the applicant is found to have employed an unauthorized alien, applicant may be subject to penalties pursuant to Sections 135.815, 285.025, and 285.535, RSMo.**

## 11. I certify that (check the applicable box):

☐ I have included a copy of the executed E-Verify Program for Employment Verification Memorandum of Understanding between the company/organization and the Department of Homeland Security, United States Citizenship and Immigration Services (DHS-USCIS) and Social Security Administration.

☐ I am not a business entity as defined in Section 285.525 (1) RSMo. Section 285.525(1) defines business entity as "any person or group of persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage or livelihood. The term "business entity" shall include but not be limited to self-employed individuals, partnerships, corporations, contractors, and subcontractors. The term "business entity" shall include any business entity that possesses a business permit, license, or tax certificate, issued by the state, any business entity that is exempt by law from obtaining such a business permit, any business entity that is operating unlawfully without such a business permit. The term "business entity" shall not include a self-employed individual with no employees or entities utilizing the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo."

12. By submitting this application, I acknowledge that the applicant shall comply with Amateur Sporting Events Tax Credit Program requirements. I further acknowledge that the applicant's failure to comply with the Program requirements shall result in the return to DED of any remaining unexpended tax credit proceeds and repayment to DED the monetary value of any expended tax credit proceeds.

13. I certify under penalties of perjury that the above statements, information contained in the application and attachments are complete, true, and correct to the best of my knowledge. I also realize that failure to disclose material information regarding the applicant, its owners, or any other pertinent facts may result in criminal prosecution.

APPLICANT SIGNATURE	PRINT NAME	TITLE	DATE
NOTARY PUBLIC EMBOSSEER SEAL	On this ____ day of _____, 20____, appeared _____ to me personally known to be the person who executed the above certification, and acknowledges and states on his/her oath to me that he/she executed the same for the purpose therein stated.		
	STATE OF _____		COUNTY _____
	NOTARY PUBLIC NAME _____	MY COMMISSION EXPIRES _____	USE RUBBER STAMP IN AREA BELOW
	NOTARY PUBLIC SIGNATURE _____		



**APPLICATION INSTRUCTIONS:**  
**Project Proposal**

**1. APPLICANT INFORMATION:**

**Name:** Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

**Type of Entity:**

- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- **Special Note:** For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

**2. PROJECT CONTACT:**

**Applicant/Owner/Other:** Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

**3. SPORTING EVENT INFORMATION:**

**Note:** If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.

**Type of Event:** Please list the sport that will be played at the Sporting Event.

**Address:** Enter the address of the project site, including city/town, state, zip code, and county.

**Event Date:** Please list the date that the sporting event will be held. If no exact date for the event has been given, please give the narrowest possible range of dates.

**4. ECONOMIC IMPACT:**

**Note:** Indicate by checking the appropriate box and entering the entities Name, based upon the type of Sporting Event Site Selection Organization, whether or not your Sporting Event Proposal falls into the category of Presumed Economic Impact or Proven Economic Impact.

**Note:** Applicants with a Presumed Economic Impact may proceed to Question #11. Applicants requiring a Proven Economic Impact must respond to Questions 5-10.

**Note:** For questions 5-10, please provide the best estimate possible. Attach any supporting documentation that assists in verifying or indicating the methodology used for calculating the estimate. Relevant documents may include historical figures from previous events site studies or surveys or other documents available.

**5. EXPECTED MISSOURI VENUE PREPARATION ACTIVITIES:**

**Note:** Not all venue preparation activities are Eligible Costs. We are asking for this information in order to better gauge the economic impact of the Sporting Event upon the state. If you need additional space, please feel free to add additional pages. With all categories listed, we are looking for money that will be spent in Missouri. Please provide a brief description of the activity to be performed in the appropriate space provided.

**Dates of Venue Preparation:** List the date range for the preparation activities.

**6. EXPECTED EVENT COSTS:**

**Note:** Not all event costs are Eligible Costs. We are asking for this information in order to better gauge the economic impact of the Sporting Event upon the state. If you need additional space, please feel free to add additional pages. With all categories listed, we are looking for money that will be spent in Missouri. Please provide a brief description of the activity to be performed in the appropriate space provided.

**7. EXPECTED EVENT TICKET AND ATTENDANCE INFORMATION:**

**Expected Attendance:** The total number of spectators (including spectators paying less than Face Value for their tickets) expected at the event.

**Estimated Local Attendees:** The total number of spectators expected to come from within a ninety miles radius of the Sporting Event.

**Estimated Out-of-State Attendees:** The total number of spectators expected to come from out of state.

**Estimated Average Ticket Sales Price:** The average Face Value of all tickets to be sold at the Sporting Event.

**Estimated Tickets Sold at Face Value:** The total number of tickets sold for Face Value, as defined in the definitions section of the Guidelines.

**8. USE OF PROPERTY:**

**Anticipated Number of Jobs Created:** Enter the number of jobs expected to be created as a result of the Tax Credits. This number should include new construction, full-time permanent, and part-time permanent jobs.

**New Construction Jobs:** Construction-related jobs created as a result of the Tax Credits.

**Full-Time Permanent Jobs:** Full-time permanent jobs created as a result of the Tax Credits. This should not include full-time equivalent jobs made up of several part-time jobs.

**Part-Time Permanent Jobs:** Part-time permanent jobs created as a result of the Tax Credits.

**9. EXPECTED VISITOR EVENT SPENDING:**

**Note:** We are asking for this information in order to better gauge the economic impact of the Sporting Event upon the state. If you need additional space, please feel free to add additional pages. With all categories listed, we are looking for money that will be spent at the Event Location and during the period immediately before, during, and after the Sporting Event. Please provide a brief description of the activity to be performed in the appropriate space provided.

**10. EXPECTED VISITOR SPENDING (Outside the Sporting Event):**

**Note:** This question is optional and should only be provided if there is an availability of Supporting Documentation. We are asking for this information in order to better gauge the economic impact of the Sporting Event upon the state. If you need additional space, please feel free to add additional pages. With all categories listed, we are looking for money that will be spent outside the Location of the Sporting Event. Please provide a brief description of the activity to be performed in the appropriate space provided.

**11. TOTAL NUMBER OF REQUESTED TAX CREDITS:**

**Eligible Costs:** List the estimated dollar value for all expected eligible costs.

**Estimated Tickets Sold at Face Value:** List the estimated number of Sporting Event tickets that will be sold at Face Value.

**Number of Tickets Multiplied by \$5:** Multiply the number of Estimated Tickets Sold at Face Value by \$5.

**Maximum Tax Credits:** Enter the lesser of Eligible Costs or the Number of Tickets Multiplied by \$5.

**12. PARTICIPATING IN THE E-VERIFY PROGRAM?**

Please indicate yes or no. Participation in the E-Verify Program is a prerequisite of receiving ASTCP tax credits.

**13. ADDITIONAL DOCUMENTS REQUIRED:**

**A copy of the draft Support Contract for the Sporting Event (if available):** Please submit a draft of the event award notification, Joinder Undertaking, Joinder Agreement, or contract to be used by the Applicant and Site Selection Organization.

**Back-up documentation:** See the individual Supporting Documentation listings under the individual sections above.

**A copy of the Memorandum of Understanding for the E-Verify Program:** The Memorandum of Understanding must be properly executed by the Applicant.

**A copy of the Sources and Uses for the Sporting Event:** The Applicant must show the available funds that will be used to conduct the Sporting Event, along with all projected expenses associated with the Sporting Event.

**Executed financing agreements:** The agreements can take the form of letters of credit, bank statements, or other documents showing that the project will have sufficient funding to take place.

**14. OTHER INCENTIVES USED:**

**Are there other State of Missouri tax credits being applied toward this project?** Select the appropriate box. If "Yes," please indicate which programs are applicable. If no other programs are being applied to the project, check "No."

**15. ASTCP – APPLICANT CERTIFICATION:**

Must be signed and notarized.

*AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the Missouri Register.*

**Title 4—DEPARTMENT OF ECONOMIC  
DEVELOPMENT**

**Division 85—Division of Business and Community  
Services**

**Chapter 9—Amateur Sporting Tax Credit Program**

**EMERGENCY RULE**

**4 CSR 85-9.035 Support Contract**

*PURPOSE: The purpose of this rule is to explain the requirements for a properly submitted support contract.*

*EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

(1) The following will be included as part of the support contract submission:

- (A) The Support Contract Submission Form, included herein; and
- (B) A final executed copy of the support contract.

(2) The department reserves the right to make reasonable request for additional documentation in order to approve or deny a Support Contract Submission Form.

(3) A project proposal must meet the following statutory criteria in order for the project to be approved for tax credits:

(A) There must be cap space available. If your project was given a reservation of tax credits at the project proposal stage, you will already have cap space allocated to your sporting event and department will review your support contract for statutory compliance;

(B) You can submit a project proposal along with a support contract submission;

(C) If the program cap has been reached, and your support contract submission would have been otherwise approved, your sporting event will be placed on administrative hold until the earlier of—

1. A date upon which there is cap space available due to other denials in the fiscal year covered by the application, at which point cap space will be reserved for the applicant; or

2. Until a date ninety (90) days following the end of the sporting event, at which point the project will be denied;

(D) A project will be denied, even if it had been previously approved, when it becomes apparent that the sporting event will not be held as indicated in the support contract. Denied projects shall have their reserved cap space allotted to other sporting events;

(E) The applicant and site selection organizations must be valid and fit within the appropriate definitions provided under 4 CSR 85-9.011;

(F) No site for a sporting event may have been chosen prior to December 1, 2012, and no support contract will be approved after August 28, 2019; and

(G) No support contract will be certified unless the site selection organization has chosen to use a location in Missouri during a competitive bidding process in which at least one (1) competitive bid came from out of state.



<b>ASTCP</b> <b>Support Contract</b>
LOG NUMBER (OFFICIAL USE ONLY)

**AMATEUR SPORTING TAX CREDIT PROGRAM  
SUPPORT CONTRACT SUBMISSION FORM**

<b>NAME OF INDIVIDUAL OR ENTITY</b>					
<b>IF APPLICANT IS A BUSINESS ENTITY:</b>			<b>IF APPLICANT IS AN INDIVIDUAL TAXPAYER:</b>		
Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited		Corporation <input type="checkbox"/> Regular <input type="checkbox"/> Subchapter S <input type="checkbox"/> Trust <input type="checkbox"/> LLC		<input type="checkbox"/> Property Owner <input type="checkbox"/> Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL		TITLE		MAILING ADDRESS	
BUSINESS ADDRESS				CITY/TOWN	
CITY/TOWN		STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE		FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)				SOCIAL SECURITY NUMBER	
NAICS CODE (See Definitions in Guidelines)		BUSINESS SIZE (Number of Employees Including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (If applicable)	
EMAIL ADDRESS				EMAIL ADDRESS	
HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					
<input type="checkbox"/> Applicant <input type="checkbox"/> Owner <input type="checkbox"/> Other (Consultant, etc.)					
NAME					
ADDRESS					
CITY/TOWN				STATE	ZIP CODE
TELEPHONE		EMAIL ADDRESS		FAX	
HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					

TYPE OF EVENT		
EVENT ADDRESS		
CITY/TOWN	STATE	ZIP CODE
COUNTY		
EVENT DATE		
PLEASE SUBMIT THE FOLLOWING ADDITIONAL DOCUMENTS:		
<input type="checkbox"/> A copy of the Support Contract for the Sporting Event		
<input type="checkbox"/> Explanation of any changes or updates to the Project Proposal		

**APPLICATION INSTRUCTIONS:**  
**Support Contract Submission**

**1. APPLICANT INFORMATION:**

**Name:** Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

**Type of Entity:**

- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- **Special Note:** For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

**2. PROJECT CONTACT:**

**Applicant/Owner/Other:** Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

**3. SPORTING EVENT INFORMATION:**

**Note:** If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.

**Type of Event:** Please list the sport that will be played at the Sporting Event.

**Address:** Enter the address of the project site, including city/town, state, zip code, and county.

**Event Date:** Please list the date that the sporting event will be held. If no exact date for the event has been given, please give the narrowest possible range of dates.

**4. ADDITIONAL DOCUMENTS REQUIRED:**

**A copy of the Support Contract for the Sporting Event:** Please submit the event award notification, Joinder Undertaking, Joinder Agreement, or contract executed by an Applicant and a Site Selection Organization.

**Explanation of any changes or updates to the Project Proposal:** Please submit an explanation of any changes or updates to your Project Proposal, such an update can come in the form of an amended Project Proposal.

*AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the Missouri Register.*

**Title 4—DEPARTMENT OF ECONOMIC  
DEVELOPMENT**

**Division 85—Division of Business and Community  
Services**

**Chapter 9—Amateur Sporting Tax Credit Program**

**EMERGENCY RULE**

**4 CSR 85-9.041 Event Notification**

*PURPOSE: The purpose of this rule is to explain the requirements for an event notification.*

*EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

- (1) The following will be included as part of the event notification:
  - (A) The Event Notification Form, included herein; and
  - (B) The schedule of prices for the sporting event.
- (2) The event notification must be submitted to the department no earlier than thirty (30) days, and no more than sixty (60) days prior to the sporting event.





<b>ASTCP EVENT NOTIFICATION</b>
LOG NUMBER _____

## AMATEUR SPORTING TAX CREDIT PROGRAM EVENT NOTIFICATION

<b>NAME OF INDIVIDUAL OR ENTITY</b>					
<b>IF APPLICANT IS A BUSINESS ENTITY:</b>			<b>IF APPLICANT IS AN INDIVIDUAL TAXPAYER:</b>		
Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited		Corporation <input type="checkbox"/> Regular <input type="checkbox"/> Subchapter S <input type="checkbox"/> Trust <input type="checkbox"/> LLC		<input type="checkbox"/> Property Owner <input type="checkbox"/> Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL		TITLE		MAILING ADDRESS	
BUSINESS ADDRESS			CITY/TOWN		
CITY/TOWN		STATE	ZIP CODE	STATE      ZIP CODE	
TELEPHONE		FAX		TELEPHONE      FAX	
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)			SOCIAL SECURITY NUMBER		
NAICS CODE (See Definitions in Guidelines)		BUSINESS SIZE (Number of Employees including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS			EMAIL ADDRESS		
HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					
<input type="checkbox"/> Applicant <input type="checkbox"/> Owner <input type="checkbox"/> Other (Consultant, etc.)					
NAME					
ADDRESS					
CITY/TOWN			STATE		ZIP CODE
TELEPHONE		EMAIL ADDRESS		FAX	
HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					

<b>TYPE OF EVENT</b>			
<b>EVENT ADDRESS</b>			
<b>CITY/TOWN</b>		<b>STATE</b>	<b>ZIP CODE</b>
<b>COUNTY</b>			
<b>EVENT DATE</b>			
<b>EXPECTED ATTENDANCE</b>		<b>ESTIMATED LOCAL ATTENDEES</b>	
<b>ESTIMATED OUT-OF-STATE ATTENDEES</b>		<b>ESTIMATED TICKETS SOLD AT FACE VALUE</b>	
<b>ARE LOCAL SPORTS TEAMS LIKELY TO PARTICIPATE IN THE SPORTING EVENT?</b>		<b>IF SO, WHAT TEAMS?</b>	

**APPLICATION INSTRUCTIONS:**  
**Event Notification**

**1. APPLICANT INFORMATION:**

**Name:** Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

**Type of Entity:**

- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- **Special Note:** For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

**2. PROJECT CONTACT:**

**Applicant/Owner/Other:** Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

**3. SPORTING EVENT INFORMATION:**

**Note:** If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.

**Type of Event:** Please list the sport that will be played at the Sporting Event.

**Address:** Enter the address of the project site, including city/town, state, zip code, and county.

**Event Date:** Please list the specific date or dates when the sporting event(s) will be held. If an alternative date will be used for reasons such as inclement weather, please list such dates. The Event Notification must be submitted to the DED during the Event Notification Period as defined above. The Event Date Listed in the Event Notification must be consistent with the Event Date listed in the Project Proposal.

**4. EXPECTED EVENT TICKET AND ATTENDANCE INFORMATION:**

**Expected Attendance:** The total number of spectators (including spectators paying less than Face Value for their tickets) expected at the event.

**Estimated Local Attendees:** The total number of spectators expected to come from within a ninety miles radius of the Sporting Event.

**Estimated Out-of-State Attendees:** The total number of spectators expected to come from out of state.

**Estimated Average Ticket Sales Price:** The average Face Value of all tickets to be sold at the Sporting Event.

**Estimated Tickets Sold at Face Value:** The total number of tickets sold for Face Value, as defined in the definitions section of the Guidelines.

*AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the Missouri Register.*

**Title 4—DEPARTMENT OF ECONOMIC  
DEVELOPMENT**

**Division 85—Division of Business and Community  
Services**

**Chapter 9—Amateur Sporting Tax Credit Program**

**EMERGENCY RULE**

**4 CSR 85-9.051 Cost Certification**

*PURPOSE: The purpose of this rule is to explain the process for submitting and approval of a final application.*

*EMERGENCY STATEMENT: Because section 67.3000, RSMo, caused the Amateur Sporting Tax Credit Program to become effective as of August 28, 2013, this emergency rule is authorized by statute, is necessary to implement this legislation, and ensures an orderly administration of the limitations on annual issuances under this program. An earlier version of this rule was originally submitted and withdrawn following consultation with individuals in the sporting industry. This new rule was developed to address concerns about the program that had arisen during that consultation process. The consultation and redrafting process delayed the submission of this rule. This rule was further delayed due to a need to ensure that no gap would exist between the implementation of this emergency rule and the proposed rule covering the same material was published in the March 3, 2014 issue of the Missouri Register. Should this emergency rule not be enacted, the Amateur Sporting Contribution Tax Credit Program will remain without implementing rules for a longer period between the date the enabling statute became effective and the date at which the proposed rule becomes effective. Without implementing rules, potential applicants in the state will remain underfunded and unable to effectively pursue opportunities for amateur sporting events to be placed in the state. Therefore, the Department of Economic Development finds a compelling governmental interest exists which requires this emergency action. A proposed rule that covers this same material was published in the March 3, 2014 issue of the Missouri Register. The scope of this emergency rule is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The Department of Economic Development believes this emergency rule is fair to all interested parties under these circumstances. This emergency rule was filed April 1, 2014, becomes effective April 11, 2014, and expires July 30, 2014.*

- (1) The following will be included as part of the final application:
  - (A) The Final Application Form, included herein;
  - (B) The eligible cost listing, or listings; and
  - (C) Documentation of qualified expenses.
- (2) The department reserves the right to make reasonable requests for additional documentation.
- (3) The Department of Economic Development (DED) will use the information submitted to determine the final amount of tax credits to be issued. Tax credits will be issued in an amount equal to the lesser of—
  - (A) The one hundred percent (100%) of eligible costs incurred by the applicant; or
  - (B) Five dollars (\$5) in tax credits for each admissions ticket sold for the sporting event.

(4) The eligibility of each cost shall be determined based upon a review of the costs submitted by the applicant. For tax credits to be issued on an eligible cost, that eligible cost must—

- (A) Be supported by a valid proof of payment;
- (B) Be supported by a valid invoice or itemized in a support contract; and
- (C) Be listed on an Eligible Cost Listing Form.



<b>ASTCP</b> <b>COST CERTIFICATION</b> LOG NUMBER (OFFICIAL USE ONLY)
---

**AMATEUR SPORTING TAX CREDIT PROGRAM  
COST CERTIFICATION FORM**

<b>NAME OF INDIVIDUAL OR ENTITY</b>					
<b>IF APPLICANT IS A BUSINESS ENTITY:</b>			<b>IF APPLICANT IS AN INDIVIDUAL TAXPAYER:</b>		
Partnership <input type="checkbox"/> General <input type="checkbox"/> Limited		Corporation <input type="checkbox"/> Regular <input type="checkbox"/> Subchapter S <input type="checkbox"/> Trust <input type="checkbox"/> LLC		<input type="checkbox"/> Property Owner <input type="checkbox"/> Other (specify) _____	
NAME OF AUTHORIZED COMPANY OFFICIAL		TITLE		MAILING ADDRESS	
BUSINESS ADDRESS			CITY/TOWN		
CITY/TOWN		STATE	ZIP CODE	STATE	ZIP CODE
TELEPHONE		FAX		TELEPHONE	FAX
TAXPAYER IDENTIFICATION NUMBER (OR SOCIAL SECURITY NUMBER)			SOCIAL SECURITY NUMBER		
NAICS CODE (See Definitions in Guidelines)		BUSINESS SIZE (Number of Employees Including Company Owners)		SPOUSE SOCIAL SECURITY NUMBER (if applicable)	
EMAIL ADDRESS			EMAIL ADDRESS		
HAS THE ENTITY/INDIVIDUAL (1a) EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					
<input type="checkbox"/> Applicant <input type="checkbox"/> Owner <input type="checkbox"/> Other (Consultant, etc.)					
NAME					
ADDRESS					
CITY/TOWN			STATE		ZIP CODE
TELEPHONE		EMAIL ADDRESS		FAX	
HAS THE 'CONTACT' EVER BEEN CONVICTED OF A VIOLATION OF THE LAWS OF ANY STATE AND, OR FEDERAL LAW? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PROVIDE THE DATE, THE COURT, THE CHARGES AT DISPOSITION AND THE CASE NUMBER.					

TYPE OF EVENT														
EVENT ADDRESS														
CITY/TOWN	STATE	ZIP CODE												
COUNTY														
EVENT DATE														
ELIGIBLE COSTS		AMOUNT												
ESTIMATED TICKETS SOLD AT FACE VALUE (SECTION 6 ABOVE)	NUMBER OF TICKETS MULTIPLIED BY \$5	AMOUNT												
MAXIMUM TAX CREDITS		AMOUNT												
<p>ARE THERE OTHER LOCAL, FEDERAL, STATE OF MISSOURI TAX CREDITS OR GRANTS BEING APPLIED TOWARD THIS PROJECT?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YES, WHICH FEDERAL OR STATE PROGRAM? (SPECIFY AMOUNT IN SPACE PROVIDED.)</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Missouri Housing Development Commission \$ _____</td> <td><input type="checkbox"/> Brownfield \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Enterprise Zone \$ _____</td> <td><input type="checkbox"/> New Business Facility \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Federal Historic Preservation \$ _____</td> <td><input type="checkbox"/> Neighborhood Assistance \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Neighborhood Preservation \$ _____</td> <td><input type="checkbox"/> Youth Opportunity \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Local Community Development Block Grant \$ _____</td> <td><input type="checkbox"/> Community Development Block Grant \$ _____</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Other (please specify program(s) and amount) _____</td> </tr> </table>			<input type="checkbox"/> Missouri Housing Development Commission \$ _____	<input type="checkbox"/> Brownfield \$ _____	<input type="checkbox"/> Enterprise Zone \$ _____	<input type="checkbox"/> New Business Facility \$ _____	<input type="checkbox"/> Federal Historic Preservation \$ _____	<input type="checkbox"/> Neighborhood Assistance \$ _____	<input type="checkbox"/> Neighborhood Preservation \$ _____	<input type="checkbox"/> Youth Opportunity \$ _____	<input type="checkbox"/> Local Community Development Block Grant \$ _____	<input type="checkbox"/> Community Development Block Grant \$ _____	<input type="checkbox"/> Other (please specify program(s) and amount) _____	
<input type="checkbox"/> Missouri Housing Development Commission \$ _____	<input type="checkbox"/> Brownfield \$ _____													
<input type="checkbox"/> Enterprise Zone \$ _____	<input type="checkbox"/> New Business Facility \$ _____													
<input type="checkbox"/> Federal Historic Preservation \$ _____	<input type="checkbox"/> Neighborhood Assistance \$ _____													
<input type="checkbox"/> Neighborhood Preservation \$ _____	<input type="checkbox"/> Youth Opportunity \$ _____													
<input type="checkbox"/> Local Community Development Block Grant \$ _____	<input type="checkbox"/> Community Development Block Grant \$ _____													
<input type="checkbox"/> Other (please specify program(s) and amount) _____														
<p>IS THE APPLICANT (BUSINESS ENTITY) ENROLLED AND PARTICIPATING IN THE E-VERIFY PROGRAM?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Missouri statutes (Section 285.525-285.555, RSMo) require any business entity receiving a state-administered tax credit to participate in a federal work authorization program, which enables employers to electronically verify employment eligibility with respect to employees working in connection with the activities that qualify the applicant for this program.</p> <p>To access the E-Verify website, go to: <a href="https://e-verify.uscis.gov/enroll">https://e-verify.uscis.gov/enroll</a></p>														
PLEASE SUBMIT THE FOLLOWING ADDITIONAL DOCUMENTS:														
<input type="checkbox"/> A copy of the Eligible Cost Listing(s)														
<input type="checkbox"/> Backup documentation for the expenses claimed on the Cost Certification Form.														

1. I certify that I am an authorized representative of the applicant and, as such, am authorized to make the statement of affirmation contained herein.
2. The information submitted by the applicant to DED in connection with this application is true and correct and such information is consistent with documents provided to lenders, other government programs, or investors. The applicant hereby authorizes DED to verify such information.
3. Neither the applicant, nor any individual with an ownership interest in the applicant:
  - a. Has committed a felony, is currently under indictment or charged with a felony, or is currently on parole or probation;
  - b. Is delinquent with respect to any non-protested federal, state or local taxes or fees;
  - c. Has filed, or is preparing to file, for bankruptcy, unless otherwise disclosed to DED; or
  - d. Has failed to fulfill any obligation under any other state or federal program, including a failure to pay as agreed any accrual upon which tax credits were issued.
4. I will inform DED, if at any time before project completion, there is any change to the certifications made in paragraphs 3(a) through 3(d) of this statement of affirmation.
5. The applicant, and any vendors the applicant will utilize to perform the work associated with the project, are registered and in good standing with the Missouri Secretary of State's Office.
6. The applicant agrees to comply with any and all agreements made pursuant to the project, upon which tax credits are issued.
7. I certify that the applicant does NOT knowingly employ any person who is an unauthorized alien and that the applicant has complied with federal law (8 U.S.C. § 1324a) requiring the examination of an appropriate document or documents to verify that each individual is not an unauthorized alien.
8. I certify that applicant is enrolled and will participate in a federal work authorization program as defined in Section 285.525(6), RSMo., with respect to employees working in connection with the activities that qualify applicant for this program. I certify that the applicant will maintain and, upon request, provide to DED documentation demonstrating applicant's participation in a federal work authorization program with respect to employees working in connection with the activities that qualify applicant for this program.
9. The applicant understands that, pursuant to section 285.530.5, RSMo, a general contractor or subcontractor of any tier shall not be liable under sections 285.525 to 285.550 when such general contractor or subcontractor contracts with its direct subcontractor who violates section 285.530.1, if the contract binding the contractor and subcontractor affirmatively states that the direct subcontractor is not knowingly in violation of section 285.530.1 and shall not henceforth be in such violation and the contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.
10. I understand that if the applicant is found to have employed an unauthorized alien, applicant may be subject to penalties pursuant to Sections 135.815, 285.025, and 285.535, RSMo.

## 11. I certify that (check the applicable box):

☐ I have included a copy of the executed E-Verify Program for Employment Verification Memorandum of Understanding between the company/organization and the Department of Homeland Security, United States Citizenship and Immigration Services (DHS-USCIS) and Social Security Administration.

☐ I am not a business entity as defined in Section 285.525 (1) RSMo. Section 285.525(1) defines business entity as "any person or group of persons performing or engaging in any activity, enterprise, profession, or occupation for gain, benefit, advantage or livelihood. The term "business entity" shall include but not be limited to self-employed individuals, partnerships, corporations, contractors, and subcontractors. The term "business entity" shall include any business entity that possesses a business permit, license, or tax certificate, issued by the state, any business entity that is exempt by law from obtaining such a business permit, any business entity that is operating unlawfully without such a business permit. The term "business entity" shall not include a self-employed individual with no employees or entities utilizing the services of direct sellers as defined in subdivision (17) of subsection 12 of section 288.034, RSMo."

12. By submitting this application, I acknowledge that the applicant shall comply with Amateur Sporting Events Tax Credit Program requirements. I further acknowledge that the applicant's failure to comply with the Program requirements shall result in the return to DED of any remaining unexpended tax credit proceeds and repayment to DED the monetary value of any expended tax credit proceeds.

13. I certify under penalties of perjury that the above statements, information contained in the application and attachments are complete, true, and correct to the best of my knowledge. I also realize that failure to disclose material information regarding the applicant, its owners, or any other pertinent facts may result in criminal prosecution.

APPLICANT SIGNATURE	PRINT NAME	TITLE	DATE
NOTARY PUBLIC EMBOSSEER SEAL	On this ____ day of _____, 20____, appeared _____ to me personally known to be the person who executed the above certification, and acknowledges and states on his/her oath to me that he/she executed the same for the purpose therein stated.		
	STATE OF _____		COUNTY _____
	NOTARY PUBLIC NAME _____	MY COMMISSION EXPIRES _____	USE RUBBER STAMP IN AREA BELOW
	NOTARY PUBLIC SIGNATURE _____		



**APPLICATION INSTRUCTIONS:**  
**COST CERTIFICATION**

**1. APPLICANT INFORMATION:**

**Name:** Provide the name of the individual or entity that is filing the application and will receive the tax credits. The tax credit certificate will be issued to the individual or entity entered as the applicant.

**Type of Entity:**

- If the applicant is a business entity, complete the appropriate information on the left. Check the appropriate box indicating the type of entity. Supply the name of an authorized company official and the address. Enter the entity's Taxpayer Identification Number. Supply the appropriate NAICS code (see Definitions in Guidelines). Enter the authorized company official's email address, if available. List the property owner.
- If the applicant is an individual, complete the appropriate information on the right. Check the appropriate box indicating if the individual is the property owner. Enter the individual's contact information. Supply the individual's Social Security Number and spouse's Social Security Number, if applicable. Enter the applicant's email address, if available. If the individual requesting tax credits is not the property owner, please list the owner.
- **Special Note:** For entities with flow-through tax treatment (e.g., partnerships, S-corporations, etc.), on a separate sheet include the name, address, and social security number or taxpayer ID number for all persons or entities with an ownership interest. Provide the percentage ownership interest for each taxpayer as of the time of the application. If the tax credits are to be certified other than pro rata according to the proportion of ownership interest, attach an executed agreement among the partners, members, or owners documenting the alternate distribution method.

**2. PROJECT CONTACT:**

**Applicant/Owner/Other:** Check the appropriate box and specify the name and contact information of the contact person. The Project Contact may be the applicant or a third-party contact. All correspondence from DED will be sent to the Project Contact.

**3. SPORTING EVENT INFORMATION:**

**Note:** If more than one Sporting Event is being applied for, please include a separate spreadsheet listing each separate Sporting Event. The spreadsheet should list all information in this section for each Sporting Event.

**Type of Event:** Please list the sport that has been played at the Sporting Event.

**Address:** Enter the address of the project site, including city/town, state, zip code, and county.

**Event Date:** Please list the date that the Sporting Event was held.

**4. TOTAL NUMBER OF REQUESTED TAX CREDITS:**

**Eligible Costs:** List the actual dollar value for all Eligible Costs.

**Tickets Sold at Face Value:** List the total number of Sporting Event tickets sold at Face Value.

**Number of Tickets Multiplied by \$5:** Multiply the number of Tickets Sold at Face Value by \$5.

**Maximum Tax Credits:** Enter the lesser of Eligible Costs or the Number of Tickets Multiplied by \$5.

**5. OTHER INCENTIVES USED:**

**Are there other State of Missouri tax credits being applied toward this project?** Select the appropriate box. If "Yes," please indicate which programs are applicable. If no other programs are being applied to the project, check "No."

**6. PARTICIPATING IN THE E-VERIFY PROGRAM?**

Please indicate yes or no. Participation in the E-Verify Program is a prerequisite of receiving ASTCP tax credits.

**7. ADDITIONAL DOCUMENTS REQUIRED:**

**A Copy of the Eligible Cost Listing Form(s):** The Eligible Cost Listing Form(s) should be created using the template provided in Appendixes A & B.

**Backup Documentation for the Eligible Cost Listing Form(s):** All costs listed on the Eligible Cost Listing Form(s) must be supported by both an Invoice and Proof of Payment. All Pledged Obligations must also be supported by the Support Contract.

**8. ASTCP – APPLICANT CERTIFICATION:**

Must be signed and notarized.

[illegible]

**Appendix B:****Template for Eligible Cost Listing Form****Pledged Obligations**

Description of Expense	Specific Part of Support Contract Requiring this Expense	Method of Payment (Include Check No.)	Date Paid	Payee	Payor	Total Amount of Expense

*AUTHORITY: section 67.3000, RSMo Supp. 2013. Original rule filed Feb. 7, 2014. Emergency rule filed April 1, 2014, effective April 11, 2014, expires July 30, 2014. A proposed rule that covers this same material was published in the March 3, 2014, issue of the **Missouri Register**.*

**T**he Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2013.

## EXECUTIVE ORDER 14-02

WHEREAS, on February 27, 1950, President Harry S. Truman issued a Presidential Proclamation establishing Armed Forces Day in the United States as a “fitting and proper ... tribute to the Armed Forces as the servants and protectors of our Nation”; and

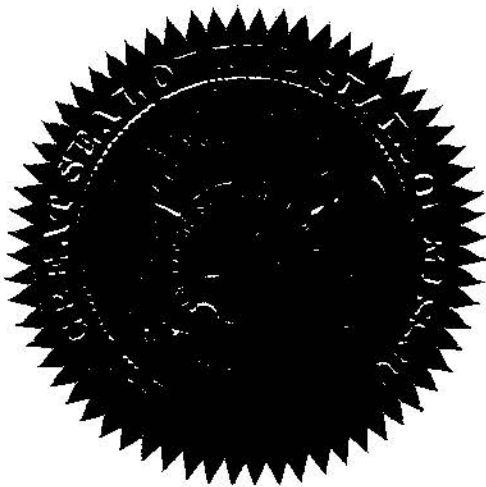
WHEREAS, throughout our nation’s history, men and women serving in our military have paid the ultimate sacrifice defending our country and protecting individual liberty; and

WHEREAS, the Honor and Remember Flag is a proper tribute to the uncompromising devotion of those members of the armed services who gave their lives in defense of these ideals; and

WHEREAS, the State of Missouri wishes to recognize and honor the sacrifice of these brave men and women from Missouri and throughout the United States; and

WHEREAS, I previously directed the Honor and Remember Flag to be flown for a thirty-day period at the State Capitol and other state facilities at the seat of government as a mark of respect for the fallen members of the Armed Forces of the United States.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, order the Honor and Remember Flag be flown at the State Capitol each Armed Forces Day, held on the third Saturday of every May, to commemorate and honor the fallen members of the Armed Forces of the United States. When displayed, the Honor and Remember Flag shall be no larger than the flags of the United States and the State of Missouri and shall be flown below such flags. If on separate poles, the Honor and Remember flag should be placed so that it is viewed to the right of the flags of the United States and the State of Missouri.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 20<sup>th</sup> day of March, 2014.

A handwritten signature in black ink, appearing to read "Jay Nixon", written over a horizontal line.

Jeremiah W. (Jay) Nixon  
Governor

ATTEST:

A handwritten signature in black ink, appearing to read "Jason Kander", written over a horizontal line.

Jason Kander  
Secretary of State

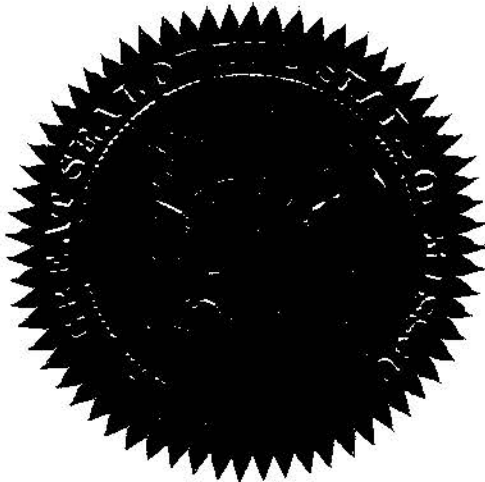
**EXECUTIVE ORDER**  
**14-03**

WHEREAS, Section 105.454(5), RSMo, requires the Governor to designate those members of his staff who have supervisory authority over each department, division or agency of the state government.

NOW THEREFORE, I, JEREMIAH W. (JAY) NIXON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby designate the following members of my staff as having supervisory authority over the following departments, divisions or agencies:

Office of Administration	Emily Kalmer
Department of Agriculture	Peter Lyskowski
Department of Conservation	Peter Lyskowski
Department of Corrections	Edward R. Ardini, Jr.
Department of Economic Development	Chris Pieper
Department of Elementary and Secondary Education	Mike Nietzel
Department of Health and Senior Services	Peter Lyskowski
Department of Higher Education	Mike Nietzel
Department of Insurance, Financial Institutions and Professional Registration	Chris Pieper
Department of Labor and Industrial Relations	Jeff Harris
Department of Mental Health	Mike Nietzel
Department of Natural Resources	Peter Lyskowski
Department of Public Safety	Edward R. Ardini, Jr.
Department of Revenue	Peter Lyskowski
Department of Social Services	Mike Nietzel
Department of Transportation	Chris Pieper
Missouri Housing Development Commission	Brian May
Boards Assigned to the Governor	Chris Pieper
Unassigned Boards and Commissions	Chris Pieper





IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 20<sup>th</sup> day of March, 2014.

A handwritten signature in black ink, appearing to read "Jeremiah W. (Jay) Nixon", written over a horizontal line.

Jeremiah W. (Jay) Nixon  
Governor

ATTEST:

A handwritten signature in black ink, appearing to read "Jason Kander", written over a horizontal line.

Jason Kander  
Secretary of State

**T**his section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order or rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

**T**he agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety-(90-) day period during which an agency shall file its order of rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the proposed rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

**Title 5—DEPARTMENT OF ELEMENTARY AND  
SECONDARY EDUCATION  
Division 20—Division of Learning Services  
Chapter 100—Office of Quality Schools**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri State Board of Education under sections 161.092, 162.081, and 168.081, RSMo Supp. 2013, and section 167.031, RSMo 2000, the board rescinds a rule as follows:

**5 CSR 20-100.170 Missouri School Improvement Program  
is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on December 2, 2013 (38 MoReg 1972). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 45—Missouri Gaming Commission  
Chapter 5—Conduct of Gaming**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Gaming Commission (MGC) under section 313.805, RSMo Supp. 2013, the commission amends

a rule as follows:

**11 CSR 45-5.237 Shipping of Electronic Gaming Devices, Gaming  
Equipment or Supplies is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2019-2020). No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed amendment on January 15, 2014. No one commented at the public hearing. No written comments were received.

**Title 11—DEPARTMENT OF PUBLIC SAFETY  
Division 45—Missouri Gaming Commission  
Chapter 9—Internal Control System**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Gaming Commission (MGC) under section 313.805, RSMo Supp. 2013, the commission adopts a rule as follows:

**11 CSR 45-9.111 is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2020-2021). Changes have been made to the *Minimum Internal Control Standards* (MICS) as incorporated by reference in Chapter K. Changes have been made to the text of the proposed rule, so it is reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed rule on January 15, 2014. Two (2) comments were received from Mike Winter, Executive Director of the Missouri Gaming Association.

COMMENT #1: The Missouri Gaming Association (MGA) would like to request MGC remove the last sentence from K §2.04 "If the transactions are not discovered until the compilation process, the transactions shall be logged by the individual performing the process."

The Multiple Transaction Log (MTL) is not a required document by the Financial Crimes Enforcement Network (FinCEN) and was created to assist casino employees in tracking a player's daily transaction. A player is added to the MTL when a single cash transaction of three thousand dollars (\$3,000) or multiple cash transactions that accumulate to three thousand dollars (\$3,000) have been observed. Additional increments of five hundred dollars (\$500) are added after that threshold is reached. The MTL is a tool to assist the frontline casino employees to determine when a player has reached the ten thousand dollars and one cent (\$10,000.01) Currency Transaction Report (CTR) threshold.

The MTL is utilized as a supporting document when filing CTRs. It is not intended to be the final document tracking all CTRs filed. It is primarily utilized by the frontline employees. It is only utilized during the compilation process as a verification tool. During the Title 31 Audit the MTL is utilized to assist in verifying the aggregation process. The Title 31 auditor will use the MTL and other reports to aggregate player's cash transactions. The auditor's job is to look for CTRs, not build an MTL. If this requirement is not removed, the Title 31 auditor would be required to spend a lot of time building the MTL when the information can be verified on separate reports. The

reports are all part of the Title 31 documents and retained for five (5) years.

RESPONSE AND EXPLANATION OF CHANGES: This sentence has been removed as requested.

COMMENT #2: The MGA would also like to address an industry concern relative to the filing of the CTR and Suspicious Activity Report (SAR) with the gaming agents. Gaming agents presently have access to this information through FinCEN. MGA believes that is still the avenue the gaming agents should use to begin their review of CTR and SAR reports.

RESPONSE: The gaming agents do not have access to this information through FinCEN unless they know the specific person for whom they need the records. Patterns of potential criminal activity can only be detected by monitoring the CTRs and SARs filed on an ongoing basis. No change has been made as a result of this comment.

#### **11 CSR 45-9.111 Minimum Internal Control Standards (MICS)—Chapter K**

(1) The commission shall adopt and publish minimum standards for internal control procedures that in the commission's opinion satisfy 11 CSR 45-9.020, as set forth in *Minimum Internal Control Standards* (MICS) Chapter K—Currency Transaction Reporting, which has been incorporated by reference herein, as published by the Missouri Gaming Commission, 3417 Knipp Dr., PO Box 1847, Jefferson City, MO 65102. Chapter K does not incorporate any subsequent amendments or additions as adopted by the commission on February 26, 2014.

### **Title 11—DEPARTMENT OF PUBLIC SAFETY Division 45—Missouri Gaming Commission Chapter 9—Internal Control System**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Gaming Commission (MGC) under section 313.805, RSMo Supp. 2013, the commission amends a rule as follows:

#### **11 CSR 45-9.119 Minimum Internal Control Standards (MICS)—Chapter S is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2022). No changes have been made to the *Minimum Internal Control Standards* (MICS) as incorporated by reference in Chapter S. No changes have been made to the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: A public hearing was held on this proposed amendment on January 15, 2014. No one commented at the public hearing. No written comments were received.

### **Title 13—DEPARTMENT OF SOCIAL SERVICES Division 40—Family Support Division Chapter 24—Community Programs**

#### **ORDER OF RULEMAKING**

By the authority vested in the Department of Social Services, Family Support Division, under section 660.376, RSMo 2000, the Family Support Division adopts a rule as follows:

#### **13 CSR 40-24.080 Formula for the Distribution of Community Service Block Grant Funds to Community Action Agencies is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2026–2031). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division (FSD) received two (2) letters commenting on the proposed rule.

COMMENT #1: One (1) comment opposed the formula for distribution of community block grant funds contained in the proposed rule. The commenter argued that the proposed rule did not comply with the existing statutory language and would significantly underfund certain Missouri community action agencies (CAA). The authorized manner in which financial assistance to CAA must be distributed is found in section 660.374, RSMo. The CAA is to receive “a portion of available Community Services Block Grant Act funds based on that agency’s poverty population relative to the state’s total poverty population.” The commenter urged that the proposed regulation did not follow this statutory authority. The commenter argued that the proposed rule should have based the Community Services Block Grant (CSBG) allocations on the CAA’s poverty population and not give each CAA a base amount of two hundred thousand dollars (\$200,000). This base funding is not supported by the statutory language, which lists proportion of poverty population as the only factor in determining distribution amounts. The commenter cited that state law requires state agencies to act within the bounds of the authority delegated to them by statute.

The commenter urged, in the alternative, that if the proposed rule was authorized to provide each CAA with a base amount, the amount chosen was capricious and arbitrary. Commenter argued that the base amount of two hundred thousand dollars (\$200,000) is not based on any analysis about the true cost of providing a level of financial assistance for a CAA to carry out community action programs. The commenter urged that the base amount will lead to inequities in funding between CAAs.

The commenter further urged that the proposed rule would lead to results that are not in the spirit of the federal CSBG Act. FSD receives funds for the local CSBG program from the federal program and it has an obligation to comply with the federal statute. One of the goals of the federal program is the “maximum participation” of low-income residents. 42 U.S.C. section 9901(2)(D). As explained in *House Conference Report 105-788*, the CSBG Act is designed to assist with “the eradication of poverty, the revitalization of high poverty neighborhoods, and the empowerment of low income families and individuals to become fully self-sufficient.”

The commenter argued that the proposed rule will not fulfill these goals. CSBG funds would not be targeted toward the areas with the greatest need or greatest number of low-income residents. As a result of the base funding, agencies with larger poverty populations will receive a smaller amount of funding than they should. For instance, for base year 2014, the commenter’s CAA will receive approximately five hundred sixty-four thousand dollars (\$564,000) less than it would under a rule based solely on poverty population. The proposed plan does not allow for maximum participation to the disadvantage of the areas that need it the most. The commenter provided data and tables supporting its argument regarding the differences in funding levels with and without the two hundred thousand dollar (\$200,000) funding base.

The commenter also asserted that since the year 2000, FSD has improperly applied a never-defined “historical factor” when making distribution determinations to the agencies. This proposed rule fails to correct this error, but continues to use the “historical factor” as a

basis for establishing funding amounts to certain specific agencies. The commenter urged that the CSBG funding formulas should be solely based on the recently updated 2011 Poverty Rates with no provision given for any type of funding “base” for all agencies. The commenter urged that its position was also supported by the rule of “equitable” versus “fair.”

To be “equitable and fair,” the commenter urged, would be to allocate funding based on how many poverty individuals each agency is responsible to serve. In support of the commenter’s argument, the commenter quoted several statements from Valerie Howard, Family Support Division Deputy Director, Income Maintenance. In summary, Ms. Howard’s statements acknowledged there was disproportionate funding formula with the CSBG and that FSD was making efforts to correct this imbalance by creating a more equitable formula.

The commenter noted that its funding allocation amount will be \$2,152,979 over the next five (5) years when, in fact the CAA will only be getting \$1,638,562, based on an eighty percent (80%) recalculation of the formula inclusive of a per agency two hundred thousand dollar (\$200,000) minimum funding base. The commenter asserted that its incorrect CSBG funding allocation amounts over the last thirteen (13) years, based on the revised poverty percentage census data, has resulted in funding shortages of over \$10.5 million.

RESPONSE: Section 660.374, RSMo, authorizes the manner in which financial assistance to CAAs must be distributed. Under the statute, CAAs are to receive “a portion” of their mandatory allocation based on that agency’s poverty population relative to the state’s total poverty population. There is nothing in federal or state law that mandates that the entire, mandatory ninety percent (90%) of the CSBG be divided pro rata between the CAA based on the poverty population. The funding formula that FSD has adopted is fully consistent with federal and state law because it assures that each CAA receive “a portion” of their CAA funding based on the agency’s poverty population relative to the state’s total poverty population while assuring that the smaller CAAs serving rural areas will receive the minimum, base amount to continue operations. The formula in the proposed rule will require that most CSBG grant funding will still be allocated to the CAA pro rata based upon the poverty population. In FY 2014, seventy-six percent (76%) of the funds will be allocated on that basis.

The Family Support Division (FSD) consulted extensively with Missouri’s CAAs during the last two (2) years in order to determine the base allocation. Based on that consultation, FSD determined that the base amount of two hundred thousand dollars (\$200,000) is the minimum amount necessary to maintain a CAA’s operations. None of the CAAs disputed that this base amount was the minimum necessary to maintain operations. This base amount is particularly necessary for those CAAs that are located in rural areas because the amount these agencies would receive if funded based one hundred percent (100%) on poverty is not enough to continue operations. FSD determined that it was critically important to keep funding levels for CAAs serving rural poverty areas at a base amount to assure that they will not have to close their doors and to continue services to rural poverty areas.

The “historical factor” noted by the commenter nearly doubled three CAAs’ poverty rates to fund them twice as much as the remaining sixteen (16) agencies. Unfortunately, the current administrators of the CSBG program were unable to identify any information in its records that documented the reason for this decision. Thus, FSD worked with Missouri’s CAAs to rectify the distribution based on this historical factor. The collaboration resulted in the new funding formula and ultimately this proposed rule.

Allocations of mandatory funds to CAAs shall be based on the most recent information on availability and amounts of CSBG funding to be awarded to Missouri by the U.S. Department of Health and Human Services, Office of Community Services as of the date that the Family Support Division issues the award. All distributions to CAAs are contingent on the availability of CSBG funds for that fiscal year. FSD may increase or decrease the funds

awarded to a CAA during the grant term depending on the availability of CSBG funds awarded to the State of Missouri by the United States Department of Health and Human Services, Office of Community Support, for the administration of the CSBG program.

No changes have been made to the rule as a result of this comment.

COMMENT #2: One commenter expressed support for these proposed rules and the CSBG funding allocation contained in these proposed regulations. The commenter believes the funding allocation was fair and in accordance with the intent of the CSBG. The updated funding allocation will assist the commenter’s agency to address the increase in people living below the poverty level as the median income in commenter’s counties has decreased.

RESPONSE: This comment does not require further response as the comment agrees with the purpose and intent of the proposed rule. No changes have been made to the rule as a result of this comment.

### Title 13—DEPARTMENT OF SOCIAL SERVICES Division 40—Family Support Division Chapter 24—Community Programs

#### ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Family Support Division, under section 660.376, RSMo 2000, the Family Support Division adopts a rule as follows:

#### 13 CSR 40-24.090 Supplemental Funding Formula for Community Action Agencies to Administer the CSBG Program is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2032–2034). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division (FSD) received two (2) letters commenting on the proposed rule.

COMMENT #1: One (1) comment opposed how FSD will supplement Community Service Block Grant (CSBG) funds for those Community Action Agencies (CAAs) that will be receiving less than the proportional share in federal fiscal year 2013. The commenter argued that the proposed rule would continue to use a current year and future portion(s) of CSBG discretionary funds to overfund agencies that do not have the poverty populations that warrant funding beyond their equitable allocation for a future period of five (5) years.

The commenter argued that since FY 2000, the flawed funding formula used by FSD had a significantly negative funding impact on the commenter’s CAA. The poverty percentage advanced by FSD for the commenter’s CAA was calculated at eleven and seventy-eight hundredths percent (11.78%) while revised census data shows that the poverty percentage stands at sixteen and thirty-five hundredths percent (16.35%). At the same time, there were at least five (5) other CAAs that were allocated funding percentages twice over what they should have received. If the commenter’s CAA were to calculate its correct CSBG funding allocation amounts over the last thirteen (13) years, based on the revised poverty percentage census data, it has had accumulative funding shortages of over \$10.5 million.

The commenter requested that since its CAA has received less than its proportional share of CSBG funding for the low-income residents it serves, can some CSBG discretionary or legislature-appropriated supplemental funds be designated to it?

RESPONSE: Section 660.374, RSMo, authorizes the manner in

which financial assistance to CAA must be distributed. Under the statute, CAAs are to receive “a portion” of their mandatory allocation based on that agency’s poverty population relative to the state’s total poverty population. There is nothing in federal or state law that mandates that the entire, mandatory ninety percent (90%) of the CSBG be divided pro rata between the CAAs based on the poverty population. The funding formula that Missouri has adopted is fully consistent with federal and state law because it assures that each CAA receive “a portion” of their funding based on the agency’s poverty population relative to the state’s total poverty population while assuring that the smaller CAA serving rural areas will receive the minimum, base amount to continue operations. The formula in the proposed rule will require that most CSBG grant funding will still be allocated to the CAA pro rata based upon the poverty population. In FY 2014, seventy-six percent (76%) of the funds will be allocated on that basis.

The Family Support Division (FSD) consulted extensively with Missouri’s CAAs during the last two (2) years in order to determine the base allocation. Based on that consultation, FSD determined that the base amount of two hundred thousand dollars (\$200,000) is the minimum amount necessary to maintain a CAA’s operations. None of the CAAs disputed that this base amount was the minimum necessary amount to maintain operations. This base amount is particularly necessary for those CAAs that are located in rural areas because the amount these agencies would receive if funded based one hundred percent (100%) on poverty is not enough to continue operations. FSD determined that it was critically important to keep funding levels for CAAs serving rural poverty areas at a base amount to assure that they will not have to close their doors and to continue services to rural poverty areas.

Allocations of mandatory funds to CAAs shall be based on the most recent information on availability and amounts of CSBG funding to be awarded to Missouri by the U.S. Department of Health and Human Services, Office of Community Services as of the date that the Family Support Division issues the award. Any and all distributions to CAAs are contingent on the availability of CSBG funds for that fiscal year. FSD may increase or decrease the funds awarded to a CAA during the grant term depending on the availability of CSBG funds awarded to the State of Missouri by the United States Department of Health and Human Services, Office of Community Support, for the administration of the CSBG program.

The request of the commenter for additional CSBG discretionary or legislature-appropriated supplemental funds be designated for the commenter’s CAA is outside the scope of this proposed rule and further comment is not required. No changes have been made to the rule as a result of this comment.

COMMENT #2: One (1) commenter expressed support for these proposed rules and the CSBG funding allocation contained in these proposed regulations. The commenter believes the funding allocation was fair and in accordance with the intent of the CSBG. The updated funding allocation will assist the commenter’s agency to address the increase in people living below the poverty level as the median income in commenter’s counties has decreased.

RESPONSE: This comment does not require further response as the comment agrees with the purpose and intent of the proposed rule. No changes have been made to the rule as a result of this comment.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 40—Family Support Division  
Chapter 24—Community Programs**

**ORDER OF RULEMAKING**

By the authority vested in the Department of Social Services, Family Support Division, under section 660.376, RSMo 2000, the Family

Support Division adopts a rule as follows:

**13 CSR 40-24.100 Use of Community Service Block Grant  
Discretionary Funds is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on December 2, 2013 (38 MoReg 2035–2038). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Family Support Division (FSD) received two (2) letters commenting on the proposed rule.

COMMENT #1: One (1) comment opposed how FSD will use Community Service Block Grant (CSBG) funds awarded to FSD by the U.S. Department of Health and Human Services for the administration of the Community Service Block Grant (CSBG) program. The commenter’s opposition to this proposed rule focuses on FSD arbitrarily awarding unsubstantiated funding, discretionary or supplemental, to agencies that “receive Community Service Block Grant (CSBG) funds for less than the proportional share...” Commenter’s Community Action Agency (CAA) has for numerous years received less than its proportional share of CSBG funding for the relative proportional poverty residents it serves. Commenter demands that some CSBG discretionary or legislature-appropriated supplemental funds be designated to its CAA for all the years it received less than the appropriate “proportional share.” The commenter urged that the low-income residents of Kansas City equally deserve and are entitled to all the array of benefits in achieving self-sufficiency afforded by appropriate funding levels of the federally-funded CSBG program.

RESPONSE: Section 660.374, RSMo, authorizes the manner in which financial assistance to CAA must be distributed. Under the statute, CAA are to receive “a portion” of their mandatory allocation based on that agency’s poverty population relative to the state’s total poverty population. There is nothing in federal or state law that mandates that the entire, mandatory ninety percent (90%) of the CSBG be divided pro rata between the CAA based on the poverty population. The funding formula that Missouri has adopted is fully consistent with federal and state law because it assures that each CAA receive “a portion” of their CAA funding based on the agency’s poverty population relative to the state’s total poverty population while assuring that the smaller CAAs serving rural areas will receive the minimum, base amount to continue operations. The formula in the proposed rule will require that most CSBG grant funding will still be allocated to the CAA pro rata based upon the poverty population. In FY 2014, seventy-six percent (76%) of the funds will be allocated on that basis.

The Family Support Division (FSD) consulted extensively with Missouri’s CAAs during the last two (2) years in order to determine the base allocation. Based on that consultation, FSD determined that the base amount of two hundred thousand dollars (\$200,000) is the minimum amount necessary to maintain a CAA’s operations. FSD determined that it was critically important to keep funding levels for CAAs serving rural poverty areas at a base amount to assure that they will not have to close their doors and to continue services to rural poverty areas.

The proposed rule appropriately sets forth criterion to allocate CSBG discretionary funds among different CAAs. The request of the commenter for additional CSBG discretionary or legislature-appropriated supplemental funds be designated for the commenter’s CAA is outside the scope of this proposed rule and further comment is not required.

No changes have been made to the rule as a result of this comment.

COMMENT #2: One (1) commenter expressed support for these proposed rules and the CSBG funding allocation contained in these

proposed regulations. The commenter believes the funding allocation was fair and in accordance with the intent of the CSBG. The updated funding allocation will assist the commenter's agency to address the increase in people living below the poverty level as the median income in commenter's counties has decreased.

RESPONSE: This comment does not require further response as the comment agrees with the purpose and intent of the proposed rule. No changes have been made to the rule as a result of this comment.

**Title 13—DEPARTMENT OF SOCIAL SERVICES  
Division 70—MO HealthNet Division  
Chapter 10—Nursing Home Program**

**ORDER OF RULEMAKING**

By the authority vested in the MO HealthNet Division under section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2013, the division amends a rule as follows:

**13 CSR 70-10.030 Prospective Reimbursement Plan for  
Nonstate-Operated Facilities for ICF/MR Services  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 245–248). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 1—General Organization**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-1.010 General Organization is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 73). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 1—General Organization**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-1.020 Public Records is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 73–74). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.010 Definitions is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 74–75). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.020 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 75–81). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received ten (10) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that under subsection (2)(B), that clarification is needed regarding what happens if a member is enrolled in another Medicare Prescription Drug Plan (Part D). RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, paragraph (2)(B)7., was added that an individual enrolled in another non-MCHCP Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage under MCHCP.

COMMENT #2: MCHCP staff commented that, under paragraph (2)(B)6., the new language regarding the deadline requirements for submission of the Retiree Enrollment form be removed and to reinstate the language from the 2013 rule. This change is required to be in alignment with section 103.085, RSMo.

RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed the amended language from paragraph (2)(B)6.

COMMENT #3: MCHCP staff commented that, under subparagraph (2)(B)6.A., this subparagraph is not in alignment with section 103.085, RSMo and should be removed.

RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed subparagraph (2)(B)6.A.

COMMENT #4: MCHCP staff commented that, under paragraph (2)(C)4., clarification is needed of how Medicare eligible survivors are enrolled and the timeframe for their enrollment.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subparagraph (2)(C)4.A. was added that Medicare eligible survivors will continue to be enrolled at the same level of coverage.

COMMENT #5: MCHCP staff commented that, under paragraph (3)(A)4., clarification is needed that married employees who elected to "roll up" coverage and do not complete enrollment during the open enrollment period will continue to be "rolled up."

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subparagraph (3)(A)4.C was added, that the combined family deductible and out-of-pocket maximum for married state employees who elected to enroll in the same health plan to meet only one (1) family deductible and out-of-pocket maximum will continue to do so if they do not complete enrollment during the open enrollment period and are defaulted into a plan.

COMMENT #6: MCHCP staff commented that, under subparagraph (3)(B)5.A., clarification is needed that a retiree who is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #7: UMR commented that subparagraph (3)(B)5.A., does not differentiate between a retiree that is not Medicare eligible and one that is. It is noted, in other language in the plan, that the non-Medicare eligible retiree that will become Medicare eligible within the next year should elect the 300 or 600 plan during open enrollment.

RESPONSE AND EXPLANATION OF CHANGE: Based on Comment #6 and Comment #7, part (3)(B)5.A.(I), was added that retirees enrolled in the High Deductible Health Plan who become Medicare eligible during the next year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #8: MCHCP staff commented that under subparagraph (3)(C)3.A., that if a terminated vested survivor is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next year, they will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, MCHCP added part (3)(C)3.A.(I), that terminated vested subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next year, will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #9: MCHCP staff commented that, under subparagraph (3)(D)3.A., clarification is needed if a long-term disability sub-

scriber is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next year, they will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, part (3)(D)3.A.(I), was added that long-term disability subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

COMMENT #10: MCHCP staff commented that, under subparagraph (3)(E)4.A., clarification is needed that if a survivor is currently enrolled in the High Deductible Health Plan and becomes Medicare eligible during the next year, they will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, part (3)(E)4.A.(I), was added that a survivor enrolled in the High Deductible Health Plan who become Medicare eligible during the next year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

## 22 CSR 10-2.020 General Membership Provisions

### (2) Eligibility Requirements.

#### (B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he receives a monthly retirement benefit from either MOSERS or from Public School Retirement System (PSRS) for state employment. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MOSERS and was employed by the Missouri Department of Conservation.

3. An employee may participate in an MCHCP dental and/or vision plan when s/he retires if s/he receives a monthly retirement benefit from MPERS.

4. If the retiree's spouse is a state active employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

5. A retiree who returns to state employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

6. If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

7. An individual enrolled in another non-MCHCP Medicare Prescription Drug Plan (Part D) is not eligible for medical coverage.

#### (C) Survivor Coverage.

1. At the time of the subscriber's death, a survivor of an active employee who is a vested subscriber and his/her dependents or a survivor of a vested subscriber who was receiving long-term disability

benefits from MOSERS or PSRS and his/her dependents may elect or continue coverage if the survivor and his/her dependents had coverage—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to subscriber's death. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. A survivor of a retiree or terminated vested subscriber may continue coverage if the survivor had MCHCP coverage as a dependent at the time of the subscriber's death.

3. If a survivor adds a new spouse to his/her coverage and the survivor subsequently dies, the new spouse is no longer eligible for coverage.

4. If a survivor or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days after the first day of the month following the death of the employee, s/he cannot enroll at a later date.

A. Medicare enrolled survivors will continue to be enrolled at the same level of coverage following the death of the subscriber.

### (3) Enrollment Procedures.

#### (A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at [www.sebes.mo.gov](http://www.sebes.mo.gov) within thirty-one (31) days of his/her hire date. If enrolling dependents, proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect coverage and/or change coverage levels during the annual open enrollment period.

3. An active employee may apply for coverage for himself/herself and/or for his/her dependents if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. An employee and his/her dependents may enroll within sixty (60) days if s/he involuntarily loses employer-sponsored coverage under one (1) of the following circumstances:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends; or

C. If an active employee or his/her dependent loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or

D. If an active employee or active employee's spouse receives a court order stating s/he is responsible for covering a dependent, the active employee may enroll the dependent in an MCHCP plan within sixty (60) days of the court order.

4. If an employee is currently enrolled in the PPO 300 or PPO 600 plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the employee is currently enrolled in, effective the first day of the next calendar year.

A. If an employee is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

B. If an employee is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

C. Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

5. If an employee is currently enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

#### (B) Retiree Coverage.

1. To enroll or continue coverage at retirement, the employee and his/her dependents must submit one (1) of the following:

A. A completed enrollment form within thirty-one (31) days of retirement date. Coverage is effective on retirement date; or

B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month's retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

C. A completed enrollment form within thirty-one (31) days with proof of prior medical coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he and his/her dependents choose to enroll in an MCHCP plan at retirement and have had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A retiree may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee and his/her dependents may enroll within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. If a retiree is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the retiree is currently enrolled in, effective the first day of the next calendar year.



A. If a retiree is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Retirees enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a retiree is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

C. If a retiree is currently enrolled in the Medicare Prescription Drug Only Plan and does not complete enrollment during the open enrollment period, the retiree and his/her Medicare eligible dependents will be enrolled in the Medicare Prescription Drug Only Plan at the same level of coverage.

6. If a retiree is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

7. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.

1. A terminated vested subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a terminated vested subscriber is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the terminated vested subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a terminated vested subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Terminated vested subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a terminated vested subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a terminated vested subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(D) Long-Term Disability Coverage.

1. A long-term disability subscriber may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. If a long-term disability subscriber is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the long-term disability subscriber is currently enrolled in, effective the first day of the next calendar year.

A. If a long-term disability subscriber is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Long-term disability subscribers enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a long-term disability subscriber is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

4. If a long-term disability subscriber is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of

coverage in the same plan(s), effective the first day of the next calendar year.

5. If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor must submit a survivor enrollment form and a copy of the death certificate within thirty-one (31) days of the first day of the month after the death of the employee.

A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.

B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the dependent must be added within thirty-one (31) days of birth, adoption, placement, or marriage.

C. If eligible dependent(s) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor may add a dependent to his/her current coverage if one (1) of the following occurs:

A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify MCHCP of the life event; or

B. Employer-sponsored group coverage loss. A survivor may enroll his/her dependent(s) within sixty (60) days if the dependent(s) involuntarily loses employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;

(II) Eligibility for employer-sponsored coverage ends;

(III) Employer contributions toward the premiums end; or

(IV) COBRA coverage ends.

3. A survivor may change from one (1) medical plan to another during open enrollment but cannot add a dependent. If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

4. If a survivor is currently enrolled in the PPO 300 or PPO 600 Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the PPO 600 Plan provided through the vendor the survivor is currently enrolled in, effective the first day of the next calendar year.

A. If a survivor is currently enrolled in the High Deductible Health Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the High Deductible Health Plan at the same level of coverage.

(I) Survivors who are enrolled in the High Deductible Health Plan who become Medicare eligible during the next plan year will be defaulted to the PPO 600 Plan if they do not complete enrollment during the open enrollment period.

B. If a survivor is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

5. If a survivor is currently enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

6. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.030 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 81-83). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received three (3) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, the July 1, 2012 date in the purpose statement should be corrected to July 1, 2002.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, the July 1, 2012 date in the purpose statement was changed to reflect the correct date for the MCHCP contribution methodology for members retiring prior to July 1, 2002.

COMMENT #2: MCHCP staff commented that, under section (3), that it should be clarified in greater detail exactly how a retiree's premium subsidy is calculated for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification for exactly how a retiree's premium subsidy is calculated for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan was made under section (3).

COMMENT #3: MCHCP staff commented that, under section (4), that it should be clarified in greater detail exactly how a retiree's premium subsidy is calculated for members enrolled in the Medicare Prescription Drug Only Plan.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification for exactly how a retiree's premium subsidy is calculated for members enrolled in the Medicare Prescription Drug Only Plan was made under section (4).

**22 CSR 10-2.030 Contributions**

*PURPOSE: This amendment revises the MCHCP contribution methodology for members retiring prior to July 1, 2002, the billing schedule and due dates for direct bill for Medicare primary Consolidated Omnibus Budget Reconciliation Act (COBRA), long-term disability, leave of absence, terminated vested and retiree and survivor members; and adds language regarding the methodology for the MCHCP contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan and the effect*

on coverage for non-payment of premium for Medicare primary subscribers.

(3) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium for members enrolled in the PPO 300, PPO 600, and the High Deductible Health Plan is based on either of the following:

(A) It is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by Missouri State Employees' Retirement System (MOSERS) or Public School Retirement System (PSRS) multiplied by two and one half percent (2.5%). The resulting product shall be capped at sixty-five percent (65%). For Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium. For non-Medicare retirees, the computed percentage is multiplied by the retiree only PPO 600 Plan total premium with the tobacco-free incentive and the partnership incentive. The resulting product is the MCHCP contribution, which shall be subtracted from the total premium of the plan chosen by the retiree. The difference is the amount of the retiree contribution toward the total premium. In addition, for Medicare retirees covering dependents, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. For Non-Medicare Retirees, MCHCP will contribute for the dependent portion of the premium the lesser of the following: two and one half percent (2.5%) multiplied by the number of full creditable years of service at retirement (capped at twenty-six (26) years) multiplied by the difference in premium of the retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive and the premium of the PPO 600 Plan at the rate tier the retiree has selected or the dollar amount the MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected. The above calculations can be written by formula as follows:

Medicare Retiree MCHCP contribution = (2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium) + Medicare Retiree MCHCP dependent contribution (if any);

Non-Medicare Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Retiree only PPO 600 Plan total premium with tobacco-free incentive and the partnership incentive + Non-Medicare Retiree MCHCP dependent contribution (if any);

Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium at the rate tier the retiree has selected - Retiree only PPO 600 Plan total premium)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected.

Non-Medicare Retiree MCHCP dependent contribution = lesser of (2.5% x full creditable years of service (up to 26 years) x (PPO 600 Plan total premium with tobacco-free incentive and partnership incentive at the rate tier the retiree has selected - Retiree only PPO 600 Plan total premium with tobacco-free incentive and partnership incentive)) or the dollar amount MCHCP contributes for the dependent portion of the PPO 600 premium for an active employee at the rate tier the retiree has selected.

(4) The Missouri Consolidated Health Care Plan (MCHCP) contribution toward the retiree premium for members enrolled in the Medicare Prescription Drug Only Plan is based on either of the following:

(A) The subsidy is calculated by using the number of full creditable years of service at retirement as reported to MCHCP by MOSERS or PSRS multiplied by two and one half percent (2.5%), and capped at sixty-five percent (65%). The computed percentage is multiplied by the Medicare Prescription Drug Only Plan premium at the rate tier the retiree selected. The resulting product is the MCHCP contribution, which shall be subtracted from the total Medicare Prescription Drug Only Plan premium. The difference is the amount of the retiree contribution toward the Medicare Prescription Drug Only Plan premium. The above calculation can be written by formula as follows: Retiree MCHCP contribution = 2.5% x full creditable years of service (up to 26 years) x Medicare Prescription Drug Only Plan premium; or

(B) For those retiring prior to July 1, 2002, the amount calculated in subsection (4)(A) is compared to fifty-two percent (52%) of the total premium for the Medicare Prescription Drug Only Plan. The retiree's subsidy is the greater of the amount calculated in subsection (4)(A) or fifty-two percent (52%) of the Medicare Prescription Drug Only Plan.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.045 Plan Utilization Review Policy is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 83-84). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.051 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 84-86). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under section (4), that it should be clarified that married active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment in order to meet only one (1) family deductible and out-of-pocket maximum.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (4), that married active employees who are MCHCP subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment to be able to meet one (1) family deductible and out-of-pocket maximum.

COMMENT #2: UMR commented that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims UMR can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.

RESPONSE: No changes have been made as a result of this comment.

## **22 CSR 10-2.051 PPO 300 Plan Benefit Provisions and Covered Charges**

(4) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security Number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

### **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.052 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 87-88). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under section (4), that it should be clarified that married active employees who are Missouri Consolidated Health Care Plan (MCHCP) subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment in order to meet only one (1) family deductible and out-of-pocket maximum.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (4), that married active employees who are MCHCP subscribers must provide the other spouse's Social Security Number (SSN) at the time of enrollment to be able to meet one (1) family deductible and out-of-pocket maximum.

COMMENT #2: UMR commented that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims UMR can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.

RESPONSE: No changes have been made as a result of this comment.

## **22 CSR 10-2.052 PPO 600 Plan Benefit Provisions and Covered Charges**

(4) Married, active employees who are MCHCP subscribers and have enrolled children may meet only one (1) family deductible and out-of-pocket maximum. Both spouses must enroll in the same medical plan option through the same carrier, and each must provide the other spouse's Social Security Number (SSN) and report the other spouse as eligible for coverage when newly hired and during the open enrollment process. In the medical plan vendor system, the spouse with children enrolled will be considered the subscriber and the spouse that does not have children enrolled will be considered a dependent. If both spouses have children enrolled the spouse with a birthday occurring first in the calendar year will be considered the subscriber. Failure to report an active employee spouse when newly hired and/or during open enrollment will result in a separate deductible and out-of-pocket maximum for both active employees.

### **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 89-91). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received six (6) comments on the proposed amendment.

COMMENT #1: UMR commented that, under section (9), UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement,

for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.

RESPONSE: No changes have been made as a result of this comment.

COMMENT #2: MCHCP staff commented that, under section (10), the reference to section (11) needs to be changed to section (13).

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, under section (10), the reference to section (11) was changed to section (13) due to renumbering.

COMMENT #3: MCHCP staff commented that, under section (12), clarification is needed that Medicare eligible dependents of non-Medicare retired, non-active subscribers are not eligible for the High Deductible Health Plan.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, subsection (12)(A) was added to reflect that Medicare eligible dependents of non-Medicare retired subscribers are not eligible for the High Deductible Health Plan.

COMMENT #4: MCHCP staff commented that, under section (14), clarification is needed regarding Health Savings Account (HSA) contributions made to members who have a balance in a Health Care Flexible Spending Account (HCFSA) on January 1.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (14), that employees who enroll in the High Deductible Health Plan during open enrollment and who have a balance in an HCFSA on January 1 of the new plan year, cannot receive an HSA contribution from MCHCP until after the HCFSA grace period ends.

COMMENT #5: MCHCP staff commented that, under subsection (14)(A), clarification is needed that employees must be an active employee on each date the MCHCP HSA contribution is made, including contributions made after the HCFSA grace period.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (14)(A), that subscribers must be an active employee on each date the MCHCP HSA contribution is made, including contributions made after the HCFSA grace period.

COMMENT #6: MCHCP staff commented that, under subsection (14)(B), clarification is needed for which months MCHCP will make an HSA contribution, including contributions made after the HCFSA grace period.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subsection (14)(B), that MCHCP will make an HSA contribution in the months of January and July. HSA contributions for subscribers who are affected by the HCFSA grace period will be made in April and July.

## **22 CSR 10-2.053 High Deductible Health Plan Benefit Provisions and Covered Charges**

(10) A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (13) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

(12) If a subscriber is enrolled in the HDHP and his/her status changes to Medicare primary during the plan year, the subscriber must enroll in the PPO 300 Plan or PPO 600 Plan within thirty-one (31) days of notice from MCHCP or if no plan selection is made, MCHCP will enroll the subscriber and his/her dependents in the PPO 600 Plan. A new plan deductible and out-of-pocket maximum will apply.

(A) Medicare eligible dependents of non-Medicare retired subscribers are not eligible for the High Deductible Health Plan.

(14) Health Savings Account (HSA) Contributions.

(A) To receive contributions from MCHCP, the employee must be an active employee on the date the contribution is made and open an HSA with the bank designated by MCHCP.

1. Employees who enroll in the High Deductible Health Plan during open enrollment who have a balance in a health care FSA on January 1 of the new plan year cannot receive an HSA contribution from MCHCP until after the health care FSA grace period ends.

(B) The MCHCP contributions will be deposited into the subscriber's HSA bi-annually on the Friday after the first Thursdays in January and July as follows:

Deposit	Subscriber Only	All other coverage levels
January	\$150.00	\$300.00
April (delayed contribution due to health care FSA balance)	\$150.00	\$300.00
July	\$150.00	\$300.00

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

#### **22 CSR 10-2.054 Medicare Supplement Plan Benefit Provisions and Covered Charges is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2014 (39 MoReg 92). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2014 (39 MoReg 92). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-2.055 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 92-104). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received four (4) comments on the proposed rule.

COMMENT #1: Fresenius Medical Care commented under section (2) that they suggest that a method for determining a defined rate of reimbursement during the transitional care period be developed. They suggested the method be based on one (1) of the following: 1) the provider must agree to the payment rate before being obligated to transitional care; or 2) define the rate of payment for transitional care as provider's billed charges; or 3) define the rate of payment as the prior contract rate.

RESPONSE AND EXPLANATION OF CHANGE: Based on Fresenius Medical Care comment, language has been added to clarify the rate of payment during the transitional period shall be the same fee as paid prior to leaving the network.

COMMENT #2: MCHCP staff commented that, under paragraph (4)(E)11., clarification is needed regarding replacement batteries for cochlear implant devices.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, paragraph (4)(E)11. was revised to include coverage for replacement batteries for cochlear implant devices.

COMMENT #3: MCHCP staff commented that, under paragraph (4)(E)27., clarification is needed regarding the coverage of professional fees for automated laboratory services.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)27., that professional charges for automated lab services performed by an out-of-network provider are not covered.

COMMENT #4: MCHCP staff commented that, under paragraph (4)(E)28., clarification is needed that newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if the newborn's mother is not covered under the plan. Newborns

covered by the High Deductible Health Plan will be subject to deductible and coinsurance.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)28., that newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if mother is not covered under the plan and that newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.

**22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges**

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the same fee as paid prior to leaving the network. Benefits eligible for transition of care include:

- (A) Upcoming surgery or prospective transplant;
- (B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;
- (C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;
- (D) Home nursing care;
- (E) Radiation therapy;
- (F) Dialysis;
- (G) Durable medical equipment;
- (H) Cancer treatment;
- (I) Clinical trials;
- (J) Physical, speech, or occupational therapy;
- (K) Hospice care;
- (L) Bariatric surgery, and follow-up per criteria covered under the plan;
- (M) Inpatient hospitalization at the time of the network change;
- (N) Mental health services; or
- (O) Related follow-up services within three (3) months of an acute injury or surgery.

(4) Covered Charges Applicable to the PPO 300 Plan, PPO 600 Plan, and HDHP.

(E) Plan benefits for the PPO 300 Plan, PPO 600 Plan, and HDHP are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);

(III) Inhalants; or  
(IV) Specific drugs (penicillins and macromolecular agents);  
B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:  
(I) Foods;  
(II) Hymenoptera venom (stinging insects);  
(III) Inhalants; or  
(IV) Specific drugs (penicillins and macromolecular agents);  
C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:  
(I) Hymenoptera venom (stinging insects); or  
(II) Inhalants;  
D. Skin Patch Testing: for diagnosing contact allergic dermatitis;  
E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);  
F. Photo Tests: for evaluating photo-sensitivity disorders;  
G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:  
(I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or  
(II) Skin testing is unreliable;  
H. Exercise Challenge Testing for exercise-induced bronchospasm;  
I. Ingestion (Oral) Challenge Test for any of the following:  
(I) Food or other substances; or  
(II) Drugs when all of the following are met:  
(a) History of allergy to a particular drug;  
(b) There is no effective alternative drug; and  
(c) Treatment with that drug class is essential;  
J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:  
(I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;  
(II) Food allergy;  
(III) Hymenoptera venom allergy (stinging insects);  
(IV) Inhalant allergy; or  
(V) Specific drugs;  
K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;  
L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:  
(I) Sensitivity to beryllium;  
(II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immunodeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;  
(III) Thymoma; and  
(IV) To predict allograft compatibility in the transplant setting;  
M. Allergy Re-testing: routine allergy re-testing is not considered medically necessary;  
N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:  
(I) Allergic (extrinsic) asthma;  
(II) Dust mite atopic dermatitis;  
(III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;  
(IV) Mold-induced allergic rhinitis;  
(V) Perennial rhinitis;

(VI) Seasonal allergic rhinitis or conjunctivitis when one (1) of the following conditions are met:  
(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;  
(b) Member has a life-threatening allergy to insect stings; or  
(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and  
(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;  
O. Other treatments: the following other treatments are covered:  
(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:  
(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;  
(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or  
(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy;  
(II) Rapid desensitization is considered experimental and investigational for other indications;  
P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy;  
2. Ambulance service. The following ambulance transport services are covered:  
A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;  
B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;  
3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;  
4. Bariatric surgery is covered when all of the following requirements have been met:  
A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:  
(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);  
(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or  
(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);  
B. The following open or laparoscopic bariatric surgery procedures are covered:  
(I) Roux-en-Y gastric bypass;  
(II) Sleeve gastrectomy;  
(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);  
(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;  
(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only—

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is cov-

ered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long-term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;

(III) Diagnostic procedures and results;

(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;



(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when—

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or if growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of systemic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to, any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease; or

(III) Peripheral neuropathy.

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

- A. Conventional: one thousand dollars (\$1,000).
- B. Programmable: two thousand dollars (\$2,000).
- C. Digital: two thousand five hundred dollars (\$2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500);

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

23. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychologi-

cal and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20)

hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered;

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and

coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborns covered by the PPO 300 or PPO 600 Plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine.

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings.

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic, or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

#### 34. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only when the basic coverage criteria and one of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom;

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

(a) Acute plantar fasciitis;

(b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;

(c) Calcaneal bursitis (acute or chronic);

(d) Calcaneal spurs (heel spurs);

(e) Conditions related to diabetes;

(f) Inflammatory conditions (e.g., sesamoiditis, sub-metatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);

(g) Medial osteoarthritis of the knee;

(h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis;

(II) Member with skeletally immature feet who has any of the following conditions:

(a) Hallux valgus deformities;

(b) In-toe or out-toe gait;

(c) Musculoskeletal weakness such as pronation or pes planus;

(d) Structural deformities such as tarsal coalitions; or

(e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the hip;

(II) To facilitate healing following an injury to the hip or related soft tissues;

(III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or

(IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

(I) To reduce pain by restricting mobility of the knee;

(II) To facilitate healing following an injury to the knee or related soft tissues;

(III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or

(IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic Footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

### 35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and

(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $\text{VO}_2\text{max}$ ) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METS); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person;

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver- provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars (\$153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars (\$179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars (\$105,000);

(II) Heart—one hundred eighty-five thousand dollars (\$185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars (\$261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars (\$142,817);

(V) Kidney—eighty thousand dollars (\$80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars (\$130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars (\$175,900);

(VIII) Pancreas—ninety-five thousand dollars (\$95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars (\$275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refractions is covered per calendar year.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.060 PPO 300 Plan, PPO 600 Plan, and HDHP  
Limitations is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 105–106). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received one (1) comment on the proposed amendment.

COMMENT #1: UMR commented that since “clinical eligibility” is not defined in the plan, these words be replaced with “medically necessary.”

RESPONSE: No changes have been made to this rule as a result of this comment.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.070 Coordination of Benefits is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 106). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.075 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 107–109). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: UMR commented under part (4)(B)2.D.(II) that the full address of the External Review organization has changed to include “HHS Federal Request.”

RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, MCHCP has added “HHS Federal Request” to the External Review organization’s address in part (4)(B)2.D.(II).

COMMENT #2: MCHCP staff commented that, under subsection (6)(K), clarification is needed that the once per lifetime of the account appeal that MCHCP may approve when a subscriber missed a deadline does not apply to statutory deadlines and voluntary cancellations.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff’s comment, clarification was made under subsection (6)(K), that this guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated.

**22 CSR 10-2.075 Review and Appeals Procedure**

(4) Appeal Process for Medical and Non-Medicare Primary Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual’s coverage under the plan based on a determination of the individual’s eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.



B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-2.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan's medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals  
PO Box 400046  
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care  
Attn: Appeals Department  
9401 Indian Creek Parkway, Suite 1300  
Overland Park, KS 66210

(b) Expedited appeals must be communicated by (913) 202-5000 or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
Attn: Pharmacy Appeals—MH3  
Mail Route BL0390  
6625 W. 78th St.  
Bloomington, MN 55439  
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request  
MAXIMUS Federal Services  
3750 Monroe Ave., Suite 705  
Pittsford, NY 14534  
or by fax to (888) 866-6190  
or to request a review online at  
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(K) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated;

(L) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment; and

(M) MCHCP may approve appeals of a late submission of a Preventive Lab form if the subscriber can provide substantiating evidence that the preventive lab screening was received timely, that the subscriber reasonably relied on the health care provider to submit the Preventive Lab form to the wellness vendor, and the health care provider failed to submit the Preventive Lab form to the wellness vendor prior to the May 31 due date.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**

### **Division 10—Health Care Plan Chapter 2—State Membership**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

#### **22 CSR 10-2.089 Pharmacy Employer Group Waiver Plan for Medicare Primary Members is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 109–112). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 2—State Membership**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-2.090 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 113–115). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received six (6) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under part (1)(A)1.I.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under part (1)(A)1.I.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D<sub>2</sub> or D<sub>3</sub> per dose.

COMMENT #2: MCHCP staff commented that under subparagraph (1)(A)3.D., the family out-of-pocket maximum of twelve thousand dollars (\$12,000) for prescription drugs is incorrect. The correct family out-of-pocket maximum is twelve thousand five hundred dollars (\$12,500).

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, the out-of-pocket maximum was corrected to twelve thousand five hundred dollars (\$12,500).

COMMENT #3: MCHCP staff commented that, under subpart (1)(B)1.D.(I)(a), clarification is needed for the percentage of coinsurance that applies to generic drugs filled through the home delivery program. The reference to birth control and tobacco cessation products should be removed from this paragraph because they are addressed in section (9) of this rule.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (1)(B)1.D.(I)(a), that the coinsurance after deductible for a generic drug on the formulary is ten percent (10%). The reference to birth control and tobacco cessation products was removed.

COMMENT #4: MCHCP staff commented that, under subpart (1)(B)1.D.(I)(b), clarification is needed for the percentage of coinsurance that applies to brand drugs filled through the home delivery program. The reference to birth control and tobacco cessation products should be removed from this subpart because they are addressed in section (9) of this rule.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under subpart (1)(B)1.D.(I)(b), that the coinsurance after deductible for a brand drug on the formulary is twenty percent (20%). The reference to birth control and tobacco cessation products was removed.

COMMENT #5: MCHCP staff commented that, under subpart (1)(B)1.D.(II)(b), clarification is needed for the percentage of coinsurance that applies to specialty brand drugs filled through the home delivery program.

**RESPONSE AND EXPLANATION OF CHANGE:** Based on MCHCP staff's comment, clarification was made under subpart (1)(B)1.D.(II)(b), that the coinsurance after deductible for a specialty brand drug on the formulary is twenty percent (20%).

**COMMENT #6:** MCHCP staff commented that, under part (1)(B)1.E.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.

**RESPONSE AND EXPLANATION OF CHANGE:** Based on MCHCP staff's comment, clarification was made under part (1)(B)1.E.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D<sub>2</sub> or D<sub>3</sub> per dose.

## 22 CSR 10-2.090 Pharmacy Benefit Summary

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician to non-Medicare primary members.

(A) PPO 300 and PPO 600.

1. Network:

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary;

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary;

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary;

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary;

(d) A member must choose how maintenance prescriptions will be filled by notifying the pharmacy benefit manager (PBM) of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to thirty-one- (31-) day supply. The

first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayment: Eight dollars (\$8) for a generic drug on the formulary list.

(b) Brand copayment: Thirty-five dollars (\$35) for a brand drug on the formulary.

(c) Non-formulary copayment: One hundred dollars (\$100) for a drug not on the formulary;

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount;

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix;

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug;

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand-name and generic drug; and

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable copayment.

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.

3. Out-of-pocket maximum. The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

A. Network and non-network out-of-pocket maximums are not separate;

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount;

C. Individual—six thousand two hundred fifty dollars (\$6,250);

D. Family—twelve thousand five hundred dollars (\$12,500).

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network:

A. Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

B. Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

C. Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy;

I. If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision; and

II. Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs covered only through network home delivery for up to thirty-one (31) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary;

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary;

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary;

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The dosage range for preventive Vitamin D is at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-2.110 General Foster Parent Membership Provisions  
is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 115–116). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 2—State Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

**22 CSR 10-2.140 is adopted.**

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 116–118). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received three (3) comments on the proposed rule.

COMMENT #1: MCHCP staff commented that throughout the rule, including the title and purpose statement, change “wellness” center to “health” center.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff’s comment, references to the wellness center were changed to health center in the title, purpose statement, sections (1), (2), (3), and (4).

COMMENT #2: MCHCP staff commented that, under section (2), clarification is needed for the list of available services provided at the health center.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff’s comment, clarification was made under section (2) that the health center provides only maintenance doses of allergy injections. Biometric screening, Emergency First Response for worksite injuries and treatment and monitoring of diabetes and hypertension were removed.

COMMENT #3: MCHCP staff commented that, under section (4), clarification is needed that an office visit includes laboratory services performed by the health center.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under section (4) that an office visit at the health center includes laboratory services performed by the health center.

## **22 CSR 10-2.140 Health Center Provisions, Charges, and Services**

*PURPOSE: This rule establishes the policy of the board of trustees in regard to provisions, charges, and services available to members of the Missouri Consolidated Health Care Plan (MCHCP) through the MCHCP health center.*

(1) Eligibility. Active employees enrolled in an MCHCP medical plan shall be eligible for and able to access the services available at the health center as described in this rule.

(2) Available Services. The health center provides access to treatment for uncomplicated minor illnesses and to preventive health care services including, but not limited to, the following:

- (A) Sore throats/ears/headache;
- (B) Strains/sprains/musculoskeletal problems;
- (C) Non-specific abdominal pain;
- (D) Non-specific chest pain;
- (E) Cough;
- (F) Sinus conditions;
- (G) Allergies/allergy injections (maintenance doses only);
- (H) Hormone injections;
- (I) Immunizations including immunization for influenza;
- (J) Rashes;
- (K) Acute urinary complaints;
- (L) Personal hygiene related problems;
- (M) Acute injuries/acute routine office procedures;
- (N) Minor surgical procedures, such as sutures for laceration treatment;
- (O) Ordinary and routine care of the nature of a visit to the doctor's office; and
- (P) Clinical Laboratory Improvement Amendments (CLIA)-waived lab services.

(3) Limitations and Exclusions.

(A) The following employees are not eligible for the health center:

1. Active employees who are not enrolled in an MCHCP medical plan;

2. Dependents of active employees; and
3. Retirees and their dependents.

(B) Services that are beyond the scope of practice of the health center including, but not limited to, the following:

1. Emergency services;
2. Urgent care services;
3. Radiology services;
4. Specialist services;
5. Pharmacy services;
6. Occupational, speech, and physical therapy services; and
7. Chiropractic services.

(4) Charges for the following services apply:

- (A) Office visit—
1. For active employees enrolled in the MCHCP PPO 300 or PPO 600 Plan, fifteen dollars (\$15) payable at the time of service;
  2. For active employees enrolled in the High Deductible Health Plan, forty-five dollars (\$45) payable at the time of service; and
  3. The office visit includes the evaluation and management of the patient and any associated laboratory services performed by the health center.

(B) Preventive care—

1. For active employees enrolled in the MCHCP PPO 300 Plan, PPO 600 Plan, or High Deductible Health Plan, preventive care is covered at one hundred percent (100%); and

2. Preventive care shall have the same meaning as in 22 CSR 10-2.055.

(C) Health center services are outside the MCHCP PPO 300 Plan, PPO 600 Plan, and High Deductible Health Plan benefits and payments for center services do not apply toward any associated deductible or out-of-pocket maximum.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**

### **Division 10—Health Care Plan**

#### **Chapter 3—Public Entity Membership**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

#### **22 CSR 10-3.010 Definitions is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 119). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## **Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN**

### **Division 10—Health Care Plan**

#### **Chapter 3—Public Entity Membership**

#### **ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

#### **22 CSR 10-3.020 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 119-120). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that the amended language under paragraph (2)(B)4., regarding the deadline requirement for submission of the Retiree Enrollment Form should be removed and the language from the 2013 rule be reinstated to align with section 103.085, RSMo.

RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed the amended language from paragraph (2)(B)4.

COMMENT #2: MCHCP staff commented that the amended language under subparagraph (2)(B)4.A., regarding the deadline requirement for submission of the Retiree Enrollment Form should be removed and the language from the 2013 rule be reinstated to align with section 103.085, RSMo.

RESPONSE AND EXPLANATION OF CHANGE: Based on this comment MCHCP has removed subparagraph (2)(B)4.A.

## 22 CSR 10-3.020 General Membership Provisions

### (2) Eligibility Requirements.

#### (B) Retiree Coverage.

1. An employee may participate in an MCHCP plan when s/he retires if s/he is fully vested in the retirement plan upon termination and the public entity remains with MCHCP. The public entity must make the benefits available to all retirees, past and future, who meet the vesting requirements. The employee may elect coverage for him/herself and dependents, provided the employee and any dependents have been continuously covered for health care benefits—

A. Through MCHCP since the effective date of the last open enrollment period;

B. Through MCHCP since the initial date of eligibility; or

C. Through group or individual medical coverage for the six (6) months immediately prior to retirement. Proof of prior group or individual coverage (letter from previous insurance carrier or former employer with dates of effective coverage and list of dependents covered) is required.

2. If the retiree's spouse is an active public entity employee or retiree and currently enrolled in MCHCP, both spouses may transfer to coverage under the plan in which his/her spouse is enrolled or from his/her spouse's coverage to his/her coverage at any time as long as both spouses are eligible for MCHCP coverage and their coverage is continuous.

3. A retiree who returns to employment and becomes eligible for benefits through MCHCP will be treated as a new employee.

4. If a retiree or his/her dependents who are eligible for coverage elect not to be continuously covered with MCHCP from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

#### 22 CSR 10-3.045 Plan Utilization Review Policy is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 120–121). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

#### 22 CSR 10-3.053 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 121–124). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: UMR commented that, under the Public Entity rules that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.

RESPONSE: No changes have been made as a result of this comment.

COMMENT #2: UMR commented that there is a reference to 22 CSR 10-2.055 and 22 CSR 10-2.045 in section (9) that should refer to 22 CSR 10-3.055 and 10-3.045 instead.

RESPONSE AND EXPLANATION OF CHANGE: MCHCP intended to reference 22 CSR 10-3.057 and 22 CSR 10-3.045 and has corrected the reference in section (9).

#### 22 CSR 10-3.053 PPO 1000 Plan Benefit Provisions and Covered Charges

(9) Services received while out of the country may be covered if the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

## Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10—Health Care Plan Chapter 3—Public Entity Membership

### ORDER OF RULEMAKING

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

#### 22 CSR 10-3.054 PPO 2000 Plan Benefit Provisions and Covered Charges is rescinded.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2014 (39 MoReg 125). No changes have been made in the proposed rescission,

so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.055 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 125–126). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: MCHCP staff commented that, under section (8), the reference to section (8) needs to be changed to section (9).

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, under section (8), the reference to section (8) was changed to section (9).

COMMENT #2: UMR commented that, under the Public Entity rules that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.

RESPONSE: No changes have been made as a result of this comment.

**22 CSR 10-3.055 High Deductible Health Plan Benefit Provisions and Covered Charges**

(8) A subscriber does not qualify for the High Deductible Health Plan (HDHP) if s/he is claimed as a dependent on another person's tax return or, except for the plans listed in section (9) of this rule, is covered under or enrolled in any other health plan that is not a high deductible health plan, including, but not limited to, the following types of insurance plans or programs:

(A) Medicare;

(B) TRICARE;

(C) A health care flexible spending account (FSA), with the exception of participation in the premium-only, limited-scope, and dependent care section;

(D) Health reimbursement account (HRA); or

(E) The member has veteran's benefits that have been used within the past three (3) months.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.056 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 126–127). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: UMR commented that, under the Public Entity rules that UMR Utilization Review does not provide prior authorization for services outside the country at this time. However, if MCHCP is in agreement, for foreign claims we can apply the same precertification rules in place for non-foreign claims. As in most cases the provider will not request prior authorization to the service being performed, the member may request a retrospective review.

RESPONSE: No changes have been made as a result of this comment.

COMMENT #2: UMR commented that there is a reference to 22 CSR 10-2.055 and 22 CSR 10-2.045 in section (8) that should refer to 22 CSR 10-3.055 and 10-3.045 instead.

RESPONSE AND EXPLANATION OF CHANGE: MCHCP intended to reference 22 CSR 10-3.057 and 22 CSR 10-3.045 and has corrected the reference in section (8).

**22 CSR 10-3.056 PPO 600 Plan Benefit Provisions and Covered Charges**

(8) Services received while out of the country may be covered if the service is included in 22 CSR 10-3.057 and will be subject to any prior authorization requirements provided for in 22 CSR 10-3.045. If the service is provided by a non-network provider, the member may be required to provide payment to the provider and then file a claim for reimbursement subject to timely filing limits.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director rescinds a rule as follows:

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges is rescinded.**

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on January 2, 2014 (39 MoReg 128). No changes have been made in the proposed rescission,

so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director adopts a rule as follows:

22 CSR 10-3.057 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on January 2, 2014 (39 MoReg 128–140). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received four (4) comments on the proposed rule.

COMMENT #1: Fresenius Medical Care commented under section (2) that they suggest that a method for determining a defined rate of reimbursement during the transitional care period be developed. They suggested the method be based on one (1) of the following: 1) the provider must agree to the payment rate before being obligated to transitional care; or 2) define the rate of payment for transitional care as provider's billed charges; or 3) define the rate of payment as the prior contract rate.

RESPONSE AND EXPLANATION OF CHANGE: Based on Fresenius Medical Care comment, language has been added to clarify that the rate of payment during the transitional period shall be the same fee as paid prior to leaving the network.

COMMENT #2: MCHCP staff commented that, under paragraph (4)(E)11., clarification is needed regarding replacement batteries for cochlear implant devices.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, paragraph (4)(E)11. was revised to include coverage for replacement batteries for cochlear implant devices.

COMMENT #3: MCHCP staff commented that, under paragraph (4)(E)27., clarification is needed regarding the coverage of professional fees for automated laboratory services.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)27., that professional charges for automated lab services performed by an out-of-network provider are not covered.

COMMENT #4: MCHCP staff commented that, under paragraph (4)(E)28., clarification is needed that newborns covered by the PPO 600 or PPO 1000 Plan will be subject to deductible and coinsurance if the newborn's mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff's comment, clarification was made under paragraph (4)(E)28., that newborns covered by the PPO 600 or PPO 1000 Plan will be subject to deductible and coinsurance if mother is not covered under the plan and that newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance.

**22 CSR 10-3.057 Medical Plan Benefit Provisions and Covered Charges**

(2) Transition of Care. A transition of care option is available for members using a hospital or dialysis facility that loses network status during the plan year. A subscriber and his/her dependents using a hospital or dialysis facility that loses network status during the plan year may apply for a ninety- (90-) day transition of care to continue receiving network benefits with that hospital or dialysis facility. The request for consideration must be submitted to the medical plan within forty-five (45) days of the last day the hospital or dialysis facility was a contracted network provider, to be eligible for transition of care benefits. A subscriber and his/her dependents may apply for additional days beyond the ninety- (90-) day transition if care is related to a moderate or high risk pregnancy, if care is during a member's second or third trimester of pregnancy, or up to eight (8) weeks postpartum. The subscriber and his/her dependents must apply for additional transition of care days prior to the end of the initial ninety- (90-) day transition of care period. Most routine services, treatment for stable conditions, minor illnesses, and elective surgeries will not be covered by transition of care benefits. The rate of payment during the transitional period shall be the same fee as paid prior to leaving the network. Benefits eligible for transition of care include:

- (A) Upcoming surgery or prospective transplant;
- (B) Services for women in their second or third trimester of pregnancy or up to eight (8) weeks postpartum;
- (C) Services for women who have been diagnosed as potentially having a moderate- or high-risk pregnancy;
- (D) Home nursing care;
- (E) Radiation therapy;
- (F) Dialysis;
- (G) Durable medical equipment;
- (H) Cancer treatment;
- (I) Clinical trials;
- (J) Physical, speech, or occupational therapy;
- (K) Hospice care;
- (L) Bariatric surgery, and follow-up per criteria covered under the plan;
- (M) Inpatient hospitalization at the time of the network change;
- (N) Mental health services; or
- (O) Related follow-up services within three (3) months of an acute injury or surgery.

(4) Covered Charges Applicable to the PPO 600 Plan, PPO 1000 Plan, and HDHP.

(A) Covered charges are only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a non-covered service. This includes services:

1. Prescribed by an appropriate provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation or exclusion; and
3. For not more than the usual, customary, and reasonable charge, as determined by the claims administrator for the services provided.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, customary, and reasonable, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
  2. The usual, customary, and reasonable charges in the area in which services and/or supplies are provided.
- (C) A provider visit to seek a second opinion.
- (D) Services in a country other than the United States. Emergency room and urgent care medical services are covered at the network



benefit. All other non-emergency services are covered at the non-network benefit.

(E) Plan benefits for the PPO 600 Plan, PPO 1000 Plan, and HDHP are as follows:

1. Allergy Testing and Immunotherapy. No coverage for non-provider allergy services or associated expenses relating to an allergic condition, including installation of air filters, air purifiers, or air ventilation system cleaning. Allergy testing and allergy immunotherapy are considered medically necessary for members with clinically significant allergic symptoms. The following tests and treatments are covered:

A. Epicutaneous (scratch, prick, or puncture) when Immunoglobulin E- (IgE-) mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents).

B. Intradermal (Intracutaneous) when IgE-mediated reactions occur to any of the following:

- (I) Foods;
- (II) Hymenoptera venom (stinging insects);
- (III) Inhalants; or
- (IV) Specific drugs (penicillins and macromolecular agents).

C. Skin or Serial Endpoint Titration (SET), also known as intradermal dilutional testing (IDT), for determining the starting dose for immunotherapy for members highly allergic to any of the following:

- (I) Hymenoptera venom (stinging insects); or
- (II) Inhalants;

D. Skin Patch Testing: for diagnosing contact allergic dermatitis;

E. Photo Patch Testing: for diagnosing photo-allergy (such as photo-allergic contact dermatitis);

F. Photo Tests: for evaluating photo-sensitivity disorders;

G. Bronchial Challenge Test: for testing with methacholine, histamine, or antigens in defining asthma or airway hyperactivity when either of the following conditions is met:

- (I) Bronchial challenge test is being used to identify new allergens for which skin or blood testing has not been validated; or
- (II) Skin testing is unreliable.

H. Exercise Challenge Testing for exercise-induced bronchospasm;

I. Ingestion (Oral) Challenge Test for any of the following:

- (I) Food or other substances; or
- (II) Drugs when all of the following are met:
  - (a) History of allergy to a particular drug;
  - (b) There is no effective alternative drug; and
  - (c) Treatment with that drug class is essential;

J. In Vitro IgE Antibody Tests (RAST, MAST, FAST, ELISA, ImmunoCAP) are covered for any of the following:

- (I) Allergic broncho-pulmonary aspergillosis (ABPA) and certain parasitic diseases;
- (II) Food allergy;
- (III) Hymenoptera venom allergy (stinging insects);
- (IV) Inhalant allergy; or
- (V) Specific drugs;

K. Total Serum IgE for diagnostic evaluation in members with known or suspected ABPA and/or hyper IgE syndrome;

L. Lymphocyte transformation tests such as lymphocyte mitogen response test, PHE stimulation test, or lymphocyte antigen response assay are covered for evaluation of persons with any of the following suspected conditions:

- (I) Sensitivity to beryllium;
- (II) Congenital or acquired immunodeficiency diseases affecting cell-mediated immunity, such as severe combined immunodeficiency, common variable immunodeficiency, X-linked immun-

odeficiency with hyper IgM, Nijmegen breakage syndrome, reticular dysgenesis, DiGeorge syndrome, Nezelof syndrome, Wiscott-Aldrich syndrome, ataxia telangiectasia, and chronic mucocutaneous candidiasis;

(III) Thymoma; and

(IV) To predict allograft compatibility in the transplant setting;

M. Allergy Re-testing: Routine allergy re-testing is not considered medically necessary;

N. Allergy immunotherapy is covered for the treatment of any of the following IgE-mediated allergies:

- (I) Allergic (extrinsic) asthma;
- (II) Dust mite atopic dermatitis;
- (III) Hymenoptera (bees, hornets, wasps, fire ants) sensitive individuals;
- (IV) Mold-induced allergic rhinitis;
- (V) Perennial rhinitis;
- (VI) Seasonal allergic rhinitis or conjunctivitis when one

(1) of the following conditions are met:

(a) Member has symptoms of allergic rhinitis or asthma after natural exposure to the allergen;

(b) Member has a life-threatening allergy to insect stings; or

(c) Member has skin test or serologic evidence of IgE-mediated antibody to a potent extract of the allergen; and

(VII) Avoidance or pharmacologic therapy cannot control allergic symptoms or member has unacceptable side effects with pharmacologic therapy;

O. Other treatments: The following other treatments are covered:

(I) Rapid, rush, cluster, or acute desensitization for members with any of the following conditions:

(a) IgE antibodies to a particular drug that cannot be treated effectively with alternative medications;

(b) Insect sting (e.g., wasps, hornets, bees, fire ants) hypersensitivity (hymenoptera); or

(c) Members with moderate to severe allergic rhinitis who need treatment during or immediately before the season of the affecting allergy; and

(II) Rapid desensitization is considered experimental and investigational for other indications;

P. Epinephrine kits, Ana-Kit, and Epi-Pen kits to prevent anaphylactic shock for members who have had life-threatening reactions to insect stings, foods, drugs, or other allergens; have severe asthma or if needed during immunotherapy.

2. Ambulance service. The following ambulance transport services are covered:

A. By ground to the nearest appropriate facility when other means of transportation would be contraindicated;

B. By air to the nearest appropriate facility when the member's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate or contraindicated;

3. Applied Behavior Analysis (ABA) for Autism is covered for children younger than age nineteen (19) years. ABA is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially-significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

4. Bariatric surgery. Bariatric surgery is covered when all of the following requirements have been met:

A. The surgery is performed at a facility accredited by one (1) of the following accreditation programs:

(I) American College of Surgeons Bariatric Surgery Center Network (ACS BSCN);

(II) American Society for Metabolic and Bariatric Surgery, Bariatric Surgery Centers of Excellence (ASMBS BSCOE); or

(III) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP);

B. The following open or laparoscopic bariatric surgery procedures are covered:

(I) Roux-en-Y gastric bypass;

(II) Sleeve gastrectomy;

(III) Biliopancreatic diversion with duodenal switch for individuals with a body mass index (BMI) greater than fifty (50);

(IV) Adjustable silicone gastric banding and adjustments of a silicone gastric banding to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following an adjustable silicone gastric banding procedure;

(V) Surgical reversal of bariatric surgery when complications of the original surgery (e.g., stricture, pouch dilatation, erosion, or band slippage) cause abdominal pain, inability to eat or drink, or cause vomiting of prescribed meals;

(VI) Revision of a previous bariatric surgical procedure or conversion to another procedure due to inadequate weight loss when one (1) of the following specific criteria has been met:

(a) There is evidence of full compliance with the previously prescribed post-operative dietary and exercise program; or

(b) There is documented clinical testing demonstrating technical failure of the original bariatric surgical procedure which caused the individual to fail achieving adequate weight loss of at least fifty percent (50%) of excess body weight or failure to achieve body weight to within thirty percent (30%) of ideal body weight at least two (2) years following the original surgery;

C. All of the following criteria have been met:

(I) The member is eighteen (18) years or older or has reached full skeletal growth, and has evidence of one (1) of the following:

(a) BMI greater than forty (40); or

(b) BMI between thirty-five (35) and thirty-nine and nine tenths (39.9) and one (1) or more of the following:

I. Type II diabetes;

II. Cardiovascular disease such as stroke, myocardial infarction, stable or unstable angina pectoris, hypertension, or coronary artery bypass; or

III. Life-threatening cardiopulmonary problems such as severe sleep apnea, Pickwickian syndrome, or obesity-related cardiomyopathy; and

(II) Demonstration that dietary attempts at weight control have been ineffective through completion of a structured diet program. Commercial weight loss programs are acceptable if completed under the direction of a provider or registered dietitian and documentation of participation is available for review. One (1) structured diet program for six (6) consecutive months or two (2) structured diet programs for three (3) consecutive months each within a two- (2-) year period prior to the request for the surgical treatment of morbid obesity are sufficient. Provider-supervised programs consisting exclusively of pharmacological management are not sufficient; and

(III) A thorough multidisciplinary evaluation within the previous twelve (12) months, which include all of the following:

(a) An evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure and all of the associated current procedural terminology codes;

(b) A separate medical evaluation from a provider other than the surgeon recommending surgery that includes a medical clearance for bariatric surgery;

(c) Completion of a psychological examination from a mental health provider evaluating the member's readiness and fitness for surgery and the necessary post-operative lifestyle changes. After the evaluation, the mental health provider must provide clearance for bariatric surgery; and

(d) A nutritional evaluation by a provider or registered dietitian;

5. Contraception and Sterilization. All Food and Drug Administration- (FDA-) approved contraceptive methods, sterilization

procedures, and patient education and counseling for all women with reproductive capacity. The following contraceptive devices and injections are covered when administered in a provider's office:

A. Available under the medical plan only:

(I) Tubal ligation;

B. Available under the prescription or medical plan—

(I) Cervical cap;

(II) Diaphragm;

(III) Implants, such as an intrauterine device (IUD);

(IV) Injection; and

(V) Vaginal ring;

6. Blood storage. Storage of whole blood, blood plasma, and blood products is covered in conjunction with medical treatment that requires immediate blood transfusion support;

7. Cardiac rehabilitation. An electrocardiographically-monitored program of outpatient cardiac rehabilitation (Phase II) is covered for specific criteria when it is individually prescribed by a provider and a formal exercise stress test is completed following the event and prior to the initiation of the program. Cardiac rehabilitation is covered for members who meet one (1) of the following criteria:

A. Acute myocardial infarction (MI) (heart attack in the last twelve (12) months);

B. Coronary artery bypass grafting (CABG);

C. Stable angina pectoris;

D. Percutaneous coronary vessel remodeling;

E. Valve replacement or repair;

F. Heart transplant;

G. Coronary artery disease (CAD) associated with chronic stable angina that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities; or

H. Heart failure that has failed to respond adequately to pharmacotherapy and is interfering with the ability to perform age-related activities of daily living and/or impairing functional abilities;

8. Chelation therapy. The administration of FDA-approved chelating agents is covered for any of the following conditions:

A. Genetic or hereditary hemochromatosis;

B. Lead overload in cases of acute or long-term lead exposure;

C. Secondary hemochromatosis due to chronic iron overload due to transfusion-dependent anemias (e.g., Thalassemias, Cooley's anemia, sickle cell anemia, sideroblastic anemia);

D. Copper overload in patients with Wilson's disease;

E. Arsenic, mercury, iron, copper, or gold poisoning when long term exposure to and toxicity has been confirmed through lab results or clinical findings consistent with metal toxicity;

F. Aluminum overload in chronic hemodialysis patients;

G. Emergency treatment of hypercalcemia;

H. Prophylaxis against doxorubicin-induced cardiomyopathy;

I. Internal plutonium, americium, or curium contamination;

or

J. Cystinuria;

9. Chiropractic services. Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) are covered when all of the following conditions are met:

A. A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function;

B. Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law;

C. The individual is involved in a treatment program that clearly documents all of the following:

(I) A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;

(II) The symptoms being treated;  
(III) Diagnostic procedures and results;  
(IV) Frequency, duration, and results of planned treatment modalities;

(V) Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and

(VI) Demonstrated progress toward significant functional gains and/or improved activity tolerances;

D. Following previous successful treatment with chiropractic care, acute exacerbation, or re-injury are covered when all of the following criteria are met:

(I) The member reached maximal therapeutic benefit with prior chiropractic treatment;

(II) The member was compliant with a self-directed home care program;

(III) Significant therapeutic improvement is expected with continued treatment; and

(IV) The anticipated length of treatment is expected to be short-term (e.g., no more than six (6) visits within a three- (3-) week period); and

E. Prior authorization by medical plan required for any visits after the first twenty-six (26) annually, if services continue to be medically necessary;

10. Clinical trials. Routine member care costs incurred as the result of a Phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition are covered when:

A. The study or investigation is conducted under an investigational new drug application reviewed by the FDA; or

B. Is a drug trial that is exempt from having such an investigational new drug application. Life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and

C. Routine member care costs include all items and services consistent with the coverage provided in plan benefits that would otherwise be covered for a member not enrolled in a clinical trial. Routine patient care costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the member; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

D. The member must be eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

E. The clinical trial must be approved or funded by one (1) of the following:

(I) National Institutes of Health (NIH);

(II) Centers for Disease Control and Prevention (CDC);

(III) Agency for Health Care Research and Quality;

(IV) Centers for Medicare & Medicaid Services (CMS);

(V) A cooperative group or center of any of the previously named agencies or the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) A study or investigation that is conducted by the Department of Veteran Affairs, the Department of Defense, or the Department of Energy and has been reviewed and approved to be comparable to the system of peer review of studies and investigations used by the NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

11. Cochlear implant device. Uniaural (monaural) or binaural (bilateral) cochlear implantation and necessary replacement batteries are covered for a member with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment when there is

reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:

A. Auditory brainstem implant. Auditory brainstem implant (ABI) covered for the diagnosis of neurofibromatosis type II, von Recklinghausen's disease, or when a member is undergoing bilateral removal of tumors of the auditory nerves, and it is anticipated that the member will become completely deaf as a result of the surgery, or the member had bilateral auditory nerve tumors removed and is now bilaterally deaf;

(I) For an adult (age eighteen (18) years or older) with BOTH of the following:

(a) Bilateral, severe to profound sensorineural hearing loss determined by a pure-tone average of seventy (70) decibels (dB) hearing loss or greater at five hundred (500) hertz (Hz), one thousand (1000) Hz and two thousand (2000) Hz; and

(b) Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of forty percent (40%) correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test (HINT) sentences, and Consonant-Nucleus-Consonant (CNC) test);

(II) For a child age twelve (12) months to seventeen (17) years, eleven (11) months with both of the following:

(a) Profound, bilateral sensorineural hearing loss with thresholds of ninety (90) dB or greater at one thousand (1000) Hz; and

(b) Limited or no benefit from a three- (3-) month trial of appropriately fitted binaural hearing aids;

(III) For children four (4) years of age or younger, with one (1) of the following:

(a) Failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test; or

(b) Less than twenty percent (20%) correct on open-set word recognition test Multisyllabic Lexical Neighborhood Test (MLNT) in conjunction with appropriate amplification and participation in intensive aural habilitation over a three- (3-) to six- (6-) month period;

(IV) For children older than four (4) years of age with one (1) of the following:

(a) Less than twelve percent (12%) correct on the Phonetically Balanced-Kindergarten Test; or

(b) Less than thirty percent (30%) correct on the HINT for children, the open-set Multisyllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; and

(V) A three- (3-) to six- (6-) month hearing aid trial has been undertaken by a child without previous experience with hearing aids;

B. Radiologic evidence of cochlear ossification;

C. The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

(I) Member must be enrolled in an educational program that supports listening and speaking with aided hearing;

(II) Member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device;

(III) Member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); and

(IV) Member must have arrangements for appropriate follow-up care, including the speech therapy required to take full advantage of this device;

D. A second cochlear implant is covered in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit;

E. The replacement of an existing cochlear implant is covered when either of the following criteria is met:

(I) Currently used component is no longer functional and cannot be repaired; or

(II) Currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living; and

F. Post-cochlear or ABI rehabilitation program (aural rehabilitation) is covered to achieve benefit from a covered device;

#### 12. Dental care.

A. Dental care is covered for treatment of trauma to the mouth, jaw, teeth, or contiguous sites, as a result of accidental injury; and

B. The administration of general anesthesia, monitored anesthesia care, and hospital charges for dental care are covered for children younger than five (5) years, the severely disabled, or a person with a medical or behavioral condition that requires hospitalization when provided in a network or non-network hospital or surgical center;

13. Durable medical equipment (DME) is covered when ordered by a provider to treat an injury or illness. DME includes, but is not limited to the following:

A. Insulin pumps;

B. Oxygen;

C. Augmentative communication devices;

D. Manual and powered mobility devices;

E. Disposable supplies that do not withstand prolonged use and are periodically replaced, including, but not limited to the following:

(I) Colostomy and ureterostomy bags;

(II) Prescription compression stockings limited to two (2) pairs or four (4) individual stockings per plan year;

F. Non-reusable disposable supplies, including, but not limited to:

(I) Bandages;

(II) Wraps;

(III) Tape;

(IV) Disposable sheets and bags;

(V) Fabric supports;

(VI) Surgical face masks;

(VII) Incontinence pads;

(VIII) Irrigating kits;

(IX) Pressure leotards; and

(X) Surgical leggings and support hose, over-the-counter medications and supplies, including oral appliances, are not covered;

G. Repair and replacement of DME is covered when any of the following criteria are met:

(I) Repairs, including the replacement of essential accessories, which are necessary to make the item or device serviceable;

(II) Routine wear and tear of the equipment renders it non-functional and the member still requires the equipment; or

(III) The provider has documented that the condition of the member changes or is growth-related;

14. Emergency room services. An emergency medical condition is defined as the manifestation of acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If a member is admitted to the hospital, s/he may be required to transfer to network facility for maximum benefit. Hospital and ancillary charges are paid as a network benefit;

15. Eye glasses and contact lenses. Coverage limited to charges incurred in connection with the fitting of eye glasses or contact lenses for initial placement immediately following cataract surgery;

16. Foot care (trimming of nails, corns, or calluses). Foot care is considered routine in nature and not covered in the absence of sys-

temic disease that has resulted in severe circulatory insufficiency or areas of desensitization in the lower extremities. Foot care services are covered when administered by a provider and—

A. When associated with systemic conditions that are significant enough to result in severe circulatory insufficiency or areas of desensitization in the lower extremities including, but not limited to any of the following:

(I) Diabetes mellitus;

(II) Peripheral vascular disease;

(III) Peripheral neuropathy; and

(IV) Evaluation/debridement of mycotic nails, in the absence of a systemic condition, when both of the following conditions are met:

(a) Pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate; and

(b) If the member is ambulatory, pain markedly limits ambulation;

17. Genetic counseling. Pre-test and post-test genetic counseling with a provider or a licensed or certified genetic counselor are covered when a member is recommended for covered heritable genetic testing.

A. Genetic counseling in connection with pregnancy management is covered only for evaluation of any of the following:

(I) Couples who are closely related genetically (e.g., consanguinity, incest);

(II) Familial cancer disorders;

(III) Individuals from ethnic groups recognized to be at increased risk for specific genetic disorders (e.g., African-Americans for sickle cell anemia, Ashkenazi (eastern European) Jews for Tay-Sachs disease);

(IV) Infertility cases where either parent is known to have a chromosomal abnormality;

(V) Primary amenorrhea, azospermia, abnormal sexual development, or failure in developing secondary sexual characteristics;

(VI) Mother is a known, or presumed carrier of an X-linked recessive disorder;

(VII) One (1) or both parents are known carriers of an autosomal recessive disorder;

(VIII) Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;

(IX) Parents of a child with mental retardation, autism, developmental delays, or learning disabilities;

(X) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities have been told their pregnancy may be at increased risk for complications or birth defects;

(XI) Pregnant women age thirty-five (35) years or older at delivery;

(XII) Pregnant women, or women planning pregnancy, exposed to potentially teratogenic, mutagenic, or carcinogenic agents such as chemicals, drugs, infections, or radiation;

(XIII) Previous unexplained stillbirth or repeated (three (3) or more; two (2) or more among infertile couples) first-trimester miscarriages, where there is suspicion of parental or fetal chromosome abnormalities; or

(XIV) When contemplating pregnancy, either parent affected with an autosomal dominant disorder;

18. Genetic testing. No coverage for testing based on family history alone, except for testing for the breast cancer susceptibility gene (BRCA). Genetic testing is covered to establish a molecular diagnosis of an inheritable disease when all of the following criteria are met:

A. The member displays clinical features or is at direct risk of inheriting the mutation in question (pre-symptomatic);

B. The result of the test will directly impact the treatment being delivered to the member;

C. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

D. After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain;

19. Hair analysis. Chemical hair analysis is covered for the diagnosis of suspected chronic arsenic poisoning. Other purposes are considered experimental and investigational;

20. Hair prostheses. Prostheses and expenses for scalp hair prostheses worn for hair loss are covered for alopecia areata or alopecia totalis for children eighteen (18) years of age or younger. The annual maximum is two hundred dollars (\$200), and the lifetime maximum is three thousand two hundred dollars (\$3,200);

21. Hearing aids (per ear). Hearing aids covered for conductive hearing loss unresponsive to medical or surgical interventions, sensorineural hearing loss, and mixed hearing loss. Covered once every two (2) years. If the cost of one (1) hearing aid exceeds the amount listed below, member is also responsible for charges over that amount.

A. Conventional: one thousand dollars (\$1,000).

B. Programmable: two thousand dollars (\$2,000).

C. Digital: two thousand five hundred dollars (\$2,500).

D. Bone Anchoring Hearing Aid (BAHA): three thousand five hundred dollars (\$3,500).

22. Hearing testing. One (1) hearing test per year. Additional hearing tests are covered if recommended by provider;

23. Home health care. Skilled home health nursing care is covered for members who are homebound because of injury or illness (i.e., the member leaves home only with considerable and taxing effort, and absences from home are infrequent or of short duration, or to receive medical care). Services must be performed by a registered nurse or licensed practical nurse, licensed therapist, or a registered dietitian. Covered services include:

A. Home visits instead of visits to the provider's office that do not exceed the usual and customary charge to perform the same service in a provider's office;

B. Intermittent nurse services. Benefits are paid for only one (1) nurse at any one (1) time, not to exceed four (4) hours per twenty-four- (24-) hour period;

C. Nutrition counseling provided by or under the supervision of a registered dietitian;

D. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a licensed therapist;

E. Medical supplies, drugs, or medication prescribed by a provider, and laboratory services to the extent that the plan would have covered them under this plan if the covered person had been in a hospital;

F. A home health care visit is defined as—

(I) A visit by a nurse providing intermittent nurse services (each visit includes up to a four- (4-) hour consecutive visit in a twenty-four- (24-) hour period if clinical eligibility for coverage is met) or a single visit by a therapist or a registered dietitian; and

G. Benefits cannot be provided for any of the following:

(I) Homemaker or housekeeping services;

(II) Supportive environment materials such as handrails, ramps, air conditioners, and telephones;

(III) Services performed by family members or volunteer workers;

(IV) "Meals on Wheels" or similar food service;

(V) Separate charges for records, reports, or transportation;

(VI) Expenses for the normal necessities of living such as food, clothing, and household supplies; and

(VII) Legal and financial counseling services, unless otherwise covered under this plan;

24. Hospice care and palliative services (inpatient or outpatient). Includes bereavement and respite care. Hospice care services, including pre-hospice evaluation or consultation, are covered when the individual is terminally ill and expected to live six (6) months or

less, potentially curative treatment for the terminal illness is not part of the prescribed plan of care, the individual or appointed designee has formally consented to hospice care (i.e., care directed mostly toward palliative care and symptom management), and the hospice services are provided by a certified/accredited hospice agency with care available twenty-four (24) hours per day, seven (7) days per week.

A. When the above criteria are met, the following hospice care services are covered:

(I) Assessment of the medical and social needs of the terminally ill person, and a description of the care to meet those needs;

(II) Inpatient care in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time home health care services;

(III) Outpatient care for other services as related to the terminal illness, which include services of a physician, physical or occupational therapy, and nutrition counseling provided by or under the supervision of a registered dietitian; and

(IV) Bereavement counseling benefits which are received by a member's close relative when directly connected to the member's death and bundled with other hospice charges. The services must be furnished within six (6) months of death;

25. Hospital (includes inpatient, outpatient, and surgical centers).

A. The following benefits are covered:

(I) Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a covered expense only when clinical eligibility for coverage is met. If the hospital has no semi-private rooms, the plan will allow the private room rate subject to usual, customary, and reasonable charges or the network rate, whichever is applicable;

(II) Intensive care unit room and board;

(III) Surgery, therapies, and ancillary services including, but not limited to:

(a) Cornea transplant;

(b) Coverage for breast reconstruction surgery or prostheses following mastectomy and lumpectomy is available to both females and males. A diagnosis of breast cancer is not required for breast reconstruction services to be covered, and the timing of reconstructive services is not a factor in coverage;

(c) Sterilization for the purpose of birth control is covered;

(d) Cosmetic/reconstructive surgery is covered to repair a functional disorder caused by disease or injury;

(e) Cosmetic/reconstructive surgery is covered to repair a congenital defect or abnormality for a member younger than nineteen (19) years; and

(f) Blood, blood plasma, and plasma expanders are covered, when not available without charge;

(IV) Inpatient mental health services are covered when authorized by a physician for treatment of a mental health disorder. Inpatient mental health services are covered, subject to all of the following:

(a) Member must be ill in more than one (1) area of daily living to such an extent that s/he is rendered dysfunctional and requires the intensity of an inpatient setting for treatment. Without such inpatient treatment, the member's condition would deteriorate;

(b) The member's mental health disorder must be treatable in an inpatient facility;

(c) The member's mental health disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the member's mental health disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region;

(d) The attending provider must be a psychiatrist. If the admitting provider is not a psychiatrist, a psychiatrist must be attending to the member within twenty-four (24) hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside of the United States, inpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending provider must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of mental health disorders;

(e) Day treatment (partial hospitalization) for mental health services means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an outpatient setting. The treatment program is generally a minimum of twenty (20) hours of scheduled programming extended over a minimum of five (5) days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such programs must be a less-restrictive alternative to inpatient treatment; and

(f) Mental health services received in a residential treatment facility that is licensed by the state in which it operates and provides treatment for mental health disorders is covered. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;

(V) Outpatient mental health services are covered if the member is at a therapeutic medical or mental health facility and treatment includes measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident. Treatment must be provided by one (1) of the following:

(a) A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided;

(b) A therapist with a doctorate or master's degree that denotes a specialty in psychiatry (Psy.D.);

(c) A state-licensed psychologist;

(d) A state-licensed or certified social worker practicing within the scope of his or her license or certification; or

(e) Licensed professional counselor; and

(VI) Treatment in a network hospital or facility by a non-network provider. Treatment received in a network hospital or facility by a non-network provider is covered at the network benefit;

26. Injections and infusions. Injections and infusions are covered. See preventive services for coverage of immunizations. See contraception and sterilization for coverage of birth control injections. Medications (specialty and non-specialty) that can be safely obtained through a pharmacy and which may be self-administered, including injectables, are not a medical plan benefit but are covered as part of the pharmacy benefit.

A. B12 injections are covered for the following conditions:

(I) Pernicious anemia;

(II) Crohn's disease;

(III) Ulcerative colitis;

(IV) Inflammatory bowel disease;

(V) Intestinal malabsorption;

(VI) Fish tapeworm anemia;

(VII) Vitamin B12 deficiency;

(VIII) Other vitamin B12 deficiency anemia;

(IX) Macrocytic anemia;

(X) Other specified megaloblastic anemias;

(XI) Megaloblastic anemia;

(XII) Malnutrition or alcoholism;

(XIII) Thrombocytopenia, unspecified;

(XIV) Dementia in conditions classified elsewhere;

(XV) Polyneuropathy in diseases classified elsewhere;

(XVI) Alcoholic polyneuropathy;

(XVII) Regional enteritis of small intestine;

(XVIII) Postgastric surgery syndromes;

(XIX) Other prophylactic chemo-therapy;

(XX) Intestinal bypass or anastomosis status;

(XXI) Acquired absence of stomach; and

(XXII) Ideopathic progressive polyneuropathy;

27. Lab, X-ray, and other diagnostic procedures. Outpatient diagnostic services are covered when tests or procedures are performed for a specific symptom and to detect or monitor a condition. Professional charges for automated lab services performed by an out-of-network provider are not covered.

28. Maternity coverage. Prenatal and postnatal care is covered. Routine prenatal office visits and screenings recommended by the Health Resources and Services Administration are covered at one hundred percent (100%). Other care is subject to the deductible and coinsurance. Newborns and their mothers are allowed hospital stays of at least forty-eight (48) hours after normal birth and ninety-six (96) hours after cesarean section birth. If discharge occurs earlier than specific time periods, the plan shall provide coverage for post-discharge care that shall consist of a two- (2-) visit minimum, at least one (1) in the home. During a hospital admission for delivery, only the mother's claims will be subject to a deductible and coinsurance when the mother is covered under the plan. The newborn will be subject to his/her own deductible and coinsurance after release from the hospital or transfer to another facility. Newborns covered by the PPO 600 or PPO 1000 Plan will be subject to deductible and coinsurance if mother is not covered under the plan. Newborns covered by the High Deductible Health Plan will be subject to deductible and coinsurance;

29. Nutritional counseling. Individualized nutritional evaluation and counseling as for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program. Counseling must be ordered by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietitian) for up to three (3) sessions annually without prior authorization. Any sessions after the three (3) may be covered upon prior authorization by the medical plan, if services continue to be medically necessary. Does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program;

30. Nutrition therapy.

A. Nutrition therapy is covered only when the following criteria are met:

(I) Nutrition therapy is the sole source of nutrients or a significant percentage of the daily caloric intake;

(II) Nutrition therapy is used in the treatment of, or in association with, a demonstrable disease, condition, or disorder;

(III) Nutrition therapy is necessary to sustain life or health;

(IV) Nutrition therapy is prescribed by a provider; and

(V) Nutrition therapy is managed, monitored, and evaluated on an on-going basis, by a provider.

B. Only the following types of nutrition therapy are covered:

(I) Enteral Nutrition (EN). EN is the provision of nutritional requirements via the gastrointestinal tract. EN can be taken orally or through a tube into the stomach or small intestine;

(II) Parenteral Nutrition Therapy (PN) and Total Parenteral Nutrition (TPN). PN is liquid nutrition administered through a vein to provide part of daily nutritional requirements. TPN is a type of PN that provides all daily nutrient needs. PN or TPN are covered when the member's nutritional status cannot be adequately maintained on oral or enteral feedings; and

(III) Intradialytic Parenteral Nutrition (IDPN). IDPN is a type of PN that is administered to members on chronic hemodialysis during dialysis sessions to provide most nutrient needs. IDPN is covered when the member is on chronic hemodialysis and nutritional status cannot be adequately maintained on oral or enteral feedings;

31. Office visit. Member encounter with a provider for health care, mental health, or substance abuse disorder in an office, clinic,

or ambulatory care facility is covered based on the service, procedure, or related treatment plan;

32. Oral surgery is covered for injury, tumors, or cysts. Oral surgery includes but is not limited to reduction of fractures and dislocation of the jaws; external incision and drainage of cellulites; incision of accessory sinuses, salivary glands, or ducts; excision of exostosis of jaws and hard palate; and frenectomy. Treatment must be initiated within sixty (60) days of accident. No coverage for dental care, including oral surgery, as a result of poor dental hygiene. Extractions of bony or partial bony impactions are excluded;

33. Orthognathic or Jaw Surgery. Orthognathic or jaw surgery is covered when one (1) of the following conditions is documented and diagnosed:

A. Acute traumatic injury, and post-surgical sequela;

B. Cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequela;

C. Cleft lip/palate (for cleft lip/palate related jaw surgery); or

D. Physical or physiological abnormality when one (1) of the following criteria is met:

(I) Anteroposterior Discrepancies—

(a) Maxillary/Mandibular incisor relationship: overjet of 5mm or more, or a 0 to a negative value (norm 2mm);

(b) Maxillary/Mandibular anteroposterior molar relationship discrepancy of 4mm or more (norm 0 to 1mm); or

(c) These values represent two (2) or more standard deviation from published norms;

(II) Vertical Discrepancies—

(a) Presence of a vertical facial skeletal deformity which is two (2) or more standard deviations from published norms for accepted skeletal landmarks;

(b) Open bite with no vertical overlap of anterior teeth or unilateral or bilateral posterior open bite greater than 2mm;

(c) Deep overbite with impingement or irritation of buccal or lingual soft tissues of the opposing arch; or

(d) Supraeruption of a dentoalveolar segment due to lack of occlusion;

(III) Transverse Discrepancies—

(a) Presence of a transverse skeletal discrepancy which is two (2) or more standard deviations from published norms; or

(b) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4mm or greater, or a unilateral discrepancy of 3mm or greater, given normal axial inclination of the posterior teeth; or

(IV) Asymmetries—

(a) Anteroposterior, transverse, or lateral asymmetries greater than 3mm with concomitant occlusal asymmetry;

(V) Masticatory (chewing) and swallowing dysfunction due to malocclusion (e.g., inability to incise or chew solid foods, choking on incompletely masticated solid foods, damage to soft tissue during mastication, malnutrition);

(VI) Speech impairment; or

(VII) Obstructive sleep apnea or airway dysfunction;

34. Orthotics.

A. Ankle-Foot Orthosis (AFO) and Knee-Ankle-Foot Orthosis (KAFO).

(I) Basic coverage criteria for AFO and KAFO used during ambulation are as follows:

(a) AFO is covered when used in ambulation for members with weakness or deformity of the foot and ankle, which require stabilization for medical reasons, and have the potential to benefit functionally;

(b) KAFO is covered when used in ambulation for members when the following criteria are met:

I. Member is covered for AFO; and

II. Additional knee stability is required; and

(c) AFO and KAFO that are molded-to-patient-model, or custom-fabricated, are covered when used in ambulation, only

when the basic coverage criteria and one (1) of the following criteria are met:

I. The member could not be fit with a prefabricated AFO;

II. AFO or KAFO is expected to be permanent or for more than six (6) months duration;

III. Knee, ankle, or foot must be controlled in more than one (1) plane;

IV. There is documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or

V. The member has a healing fracture which lacks normal anatomical integrity or anthropometric proportions;

(II) AFO and KAFO Not Used During Ambulation.

(a) AFO and KAFO not used in ambulation are covered if the following criteria are met:

I. Passive range of motion test was measured with a goniometer and documented in the medical record;

II. Documentation of an appropriate stretching program administered under the care of provider or caregiver;

III. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (10°) (i.e., a non-fixed contracture);

IV. Reasonable expectation of the ability to correct the contracture;

V. Contracture is interfering or expected to interfere significantly with the patient's functional abilities; and

VI. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons; or

VII. Member has plantar fasciitis.

(b) Replacement interface for AFO or KAFO is covered only if member continues to meet coverage criteria and is limited to a maximum of one (1) per six (6) months.

B. Cast Boot, Post-Operative Sandal or Shoe, or Healing Shoe. A cast boot, post-operative sandal or shoe, or healing shoe is covered for one (1) of the following indications:

(I) To protect a cast from damage during weight-bearing activities following injury or surgery;

(II) To provide appropriate support and/or weight-bearing surface to a foot following surgery;

(III) To promote good wound care and/or healing via appropriate weight distribution and foot protection; or

(IV) When the patient is currently receiving treatment for lymphedema and the foot cannot be fitted into conventional footwear.

C. Cranial Orthoses. Cranial orthosis is covered for Synostotic and Non-Synostotic Plagiocephaly. Plagiocephaly is an asymmetrically shaped head. Synostotic Plagiocephaly is due to premature closure of cranial sutures. Non-Synostotic Plagiocephaly is from positioning or deformation of the head. Cranial orthosis is the use of a special helmet or band on the head which aids in molding the shape of the cranium to normal. Initial reimbursement shall cover any subsequent revisions.

D. Elastic Supports. Elastic supports are covered when prescribed for one (1) of the following indications:

(I) Severe or incapacitating vascular problems, such as acute thrombophlebitis, massive venous stasis, or pulmonary embolism;

(II) Venous insufficiency;

(III) Varicose veins;

(IV) Edema of lower extremities;

(V) Edema during pregnancy; or

(VI) Lymphedema.

E. Footwear Incorporated Into a Brace for Members with Skeletally Mature Feet. Footwear incorporated into a brace must be billed by the same supplier billing for the brace. The following types of footwear incorporated into a brace are covered:

(I) Orthopedic footwear;

(II) Other footwear such as high top, depth inlay, or custom.

(III) Heel replacements, sole replacements, and shoe transfers involving shoes on a brace;

(IV) Inserts for a shoe that is an integral part of a brace and are required for the proper functioning of the brace; or

(V) Other shoe modifications if they are on a shoe that is an integral part of a brace and are required for the proper functioning of the brace.

F. Foot Orthoses. Custom, removable foot orthoses are covered for members who meet the following criteria:

(I) Member with skeletally mature feet who has any of the following conditions:

- (a) Acute plantar fasciitis;
- (b) Acute sport-related injuries with diagnoses related to inflammatory problems such as bursitis or tendonitis;
- (c) Calcaneal bursitis (acute or chronic);
- (d) Calcaneal spurs (heel spurs);
- (e) Conditions related to diabetes;
- (f) Inflammatory conditions (e.g., sesamoiditis, submetatarsal bursitis, synovitis, tenosynovitis, synovial cyst, osteomyelitis, and plantar fascial fibromatosis);
- (g) Medial osteoarthritis of the knee;
- (h) Musculoskeletal/arthropathic deformities including deformities of the joint or skeleton that impairs walking in a normal shoe (e.g., bunions, hallux valgus, talipes deformities, pes deformities, or anomalies of toes);

(i) Neurologically impaired feet including neuroma, tarsal tunnel syndrome, ganglionic cyst;

(j) Neuropathies involving the feet, including those associated with peripheral vascular disease, diabetes, carcinoma, drugs, toxins, and chronic renal disease; or

(k) Vascular conditions including ulceration, poor circulation, peripheral vascular disease, Buerger's disease (thromboangiitis obliterans), and chronic thrombophlebitis; and

(II) Member with skeletally immature feet who has any of the following conditions:

- (a) Hallux valgus deformities;
- (b) In-toe or out-toe gait;
- (c) Musculoskeletal weakness such as pronation or pes planus;
- (d) Structural deformities such as tarsal coalitions; or
- (e) Torsional conditions such as metatarsus adductus, tibial torsion, or femoral torsion).

G. Helmets. Helmets are covered when cranial protection is required due to a documented medical condition that makes the member susceptible to injury during activities of daily living.

H. Hip Orthosis. Hip orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the hip;
- (II) To facilitate healing following an injury to the hip or related soft tissues;
- (III) To facilitate healing following a surgical procedure of the hip or related soft tissue; or
- (IV) To otherwise support weak hip muscles or a hip deformity.

I. Knee Orthosis. Knee orthosis is covered for one (1) of the following indications:

- (I) To reduce pain by restricting mobility of the knee;
- (II) To facilitate healing following an injury to the knee or related soft tissues;
- (III) To facilitate healing following a surgical procedure on the knee or related soft tissue; or
- (IV) To otherwise support weak knee muscles or a knee deformity.

J. Orthopedic footwear for Diabetic Members.

(I) Orthopedic footwear, therapeutic shoes, inserts, or modifications to therapeutic shoes are covered for diabetic members if any following criteria are met:

(a) Previous amputation of the other foot or part of either foot;

(b) History of previous foot ulceration of either foot;

(c) History of pre-ulcerative calluses of either foot;

(d) Peripheral neuropathy with evidence of callus formation of either foot;

(e) Foot deformity of either foot; or

(f) Poor circulation in either foot.

(II) Coverage is limited to one (1) of the following within one (1) year:

(a) One (1) pair of custom molded shoes (which includes inserts provided with these shoes) and two (2) additional pairs of inserts;

(b) One (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removable inserts provided with such shoes); or

(c) Up to three (3) pairs of inserts not dispensed with diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed.

K. Orthotic-Related Supplies. Orthotic-related supplies are covered when necessary for the function of the covered orthotic device.

L. Spinal Orthoses. A thoracic-lumbar-sacral orthosis, lumbar orthosis, lumbar-sacral orthosis, and cervical orthosis are covered for the following indications:

(I) To reduce pain by restricting mobility of the trunk;

(II) To facilitate healing following an injury to the spine or related soft tissues;

(III) To facilitate healing following a surgical procedure of the spine or related soft tissue; or

(IV) To otherwise support weak spinal muscles or a deformed spine.

M. Trusses. Trusses are covered when a hernia is reducible with the application of a truss.

N. Upper Limb Orthosis. Upper limb orthosis is covered for the following indications:

(I) To reduce pain by restricting mobility of the joint(s);

(II) To facilitate healing following an injury to the joint(s) or related soft tissues; or

(III) To facilitate healing following a surgical procedure of the joint(s) or related soft tissue.

O. Orthotic Device Replacement. When repairing an item that is no longer cost-effective and is out of warranty, the plan will consider replacing the item subject to review of medical necessity and life expectancy of the device;

35. Preventive services.

A. Services recommended by the U.S. Preventive Services Task Force (categories A and B).

B. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

C. Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration.

D. Preventive care and screenings for women supported by the Health Resources and Services Administration.

E. Annual physical exams and routine lab and X-ray services ordered as part of the annual exam. One (1) exam per calendar year is covered. Additional visits as needed to obtain all necessary preventive services are covered for women depending on a woman's health status, health needs, and other risk factors. For benefits to be covered as preventive, including X-rays and lab services, they must be coded by your physician as routine, without indication of an injury or illness.

F. Cancer screenings—

(I) Mammograms—one (1) exam per year, no age limit;

(II) Pap smears—one (1) per year, no age limit;

(III) Prostate—one (1) per year, no age limit; and



(IV) Colorectal screening—One (1) flexible sigmoidoscopy, colonoscopy, or double contrast barium enema per year covered as preventive even if the primary diagnosis is not a preventive code provided a preventive code is included in connection with the screening. Virtual colonoscopy covered as diagnostic only. Additional colorectal screenings covered as diagnostic unless otherwise specified.

G. Zoster vaccination (shingles)—The zoster vaccine is covered for members age of fifty (50) years and older;

36. Prostheses (prosthetic devices). Basic equipment that meets medical needs. Repair and replacement is covered due to normal wear and tear, if there is a change in medical condition, or if growth-related;

37. Pulmonary rehabilitation. Comprehensive, individualized, goal-directed outpatient pulmonary rehabilitation covered for pre- and post-operative intervention for lung transplantation and lung volume reduction surgery (LVRS) or when all of the following apply:

A. Member has a reduction of exercise tolerance that restricts the ability to perform activities of daily living (ADL) or work;

B. Member has chronic pulmonary disease (including asthma, emphysema, chronic bronchitis, chronic airflow obstruction, cystic fibrosis, alpha-1 antitrypsin deficiency, pneumoconiosis, asbestosis, radiation pneumonitis, pulmonary fibrosis, pulmonary alveolar proteinosis, pulmonary hemosiderosis, fibrosing alveolitis), or other conditions that affect pulmonary function such as ankylosing spondylitis, scoliosis, myasthenia gravis, muscular dystrophy, Guillain-Barré syndrome, or other infective polyneuritis, sarcoidosis, paralysis of diaphragm, or bronchopulmonary dysplasia; and

C. Member has a moderate to moderately severe functional pulmonary disability, as evidenced by either of the following, and does not have any concomitant medical condition that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g., symptomatic coronary artery disease, congestive heart failure, myocardial infarction within the last six (6) months, dysrhythmia, active joint disease, claudication, malignancy):

(I) A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake ( $VO_2$ max) equal to or less than twenty milliliters per kilogram per minute (20 ml/kg/min), or about five (5) metabolic equivalents (METs); or

(II) Pulmonary function tests showing that either the Forced Expiratory Volume in One Second (FEV1), Forced Vital Capacity (FVC), FEV1/FVC, or Diffusing Capacity of the Lung for Carbon Monoxide (DLCO) is less than sixty percent (60%) of that predicted;

38. Skilled Nursing Facility. Skilled nursing facility services are covered up to one hundred twenty (120) days per calendar year;

39. Bone Growth Stimulators. Implantable bone growth stimulators are covered as an outpatient surgery benefit. The following nonimplantable bone growth stimulators are covered as a durable medical equipment benefit:

A. Ultrasonic osteogenesis stimulator (e.g., the Sonic Accelerated Fracture Healing System (SAFHS)) to accelerate healing of fresh fractures, fusions, or delayed unions at either of the following high-risk sites:

(I) Fresh fractures, fusions, or delayed unions of the shaft (diaphysis) of the tibia that are open or segmental; or

(II) Fresh fractures, fusions, or delayed unions of the scaphoid (carpal navicular);

B. Ultrasonic osteogenesis stimulator for non-unions, failed arthrodesis, and congenital pseudarthrosis (pseudoarthrosis) of the appendicular skeleton if there has been no progression of healing for three (3) or more months despite appropriate fracture care; or

C. Direct current electrical bone-growth stimulator is covered for the following indications:

(I) Delayed unions of fractures or failed arthrodesis at high-risk sites (i.e., open or segmental tibial fractures, carpal navicular fractures);

(II) Non-unions, failed fusions, and congenital pseudarthrosis where there is no evidence of progression of healing for three (3) or more months despite appropriate fracture care; or

(III) Members who are at high risk for spinal fusion failure when any of the following criteria is met:

(a) A multiple-level fusion entailing three (3) or more vertebrae (e.g., L3 to L5, L4 to S1, etc.);

(b) Grade II or worse spondylolisthesis; or

(c) One (1) or more failed fusions.

40. Telehealth Services. Telehealth services are covered for the diagnosis, consultation, or treatment of a member on the same basis that the service would be covered when it is delivered in person.

41. Therapy. Physical, occupational, and speech therapy are covered when prescribed by a provider and subject to the provisions below:

A. Physical therapy.

(I) Physical therapy must meet the following criteria:

(a) The program is designed to improve lost or impaired physical function or reduce pain resulting from illness, injury, congenital defect, or surgery;

(b) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(c) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

B. Occupational therapy must meet the following criteria:

(I) The program is designed to improve or compensate for lost or impaired physical functions, particularly those affecting activities of daily living, resulting from illness, injury, congenital defect, or surgery;

(II) The program is expected to result in significant therapeutic improvement over a clearly defined period of time; and

(III) The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals;

C. Speech therapy.

(I) All of the following criteria must be met for coverage of speech therapy:

(a) The therapy requires one-to-one intervention and supervision of a speech-language pathologist;

(b) The therapy plan includes specific tests and measures that will be used to document significant progress every two (2) weeks;

(c) Meaningful improvement is expected;

(d) The therapy includes a transition from one-to-one supervision to a self- or caregiver-provided maintenance program upon discharge; and

(e) One (1) of the following:

I. Member has severe impairment of speech-language; and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests to measure the extent of the impairment, performance deviation, and language and pragmatic skill assessment levels; or

II. Member has a significant voice disorder that is the result of anatomic abnormality, neurological condition, or injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, post-operative vocal cord surgery);

42. Transplants. Stem cell, kidney, liver, heart, lung, pancreas, small bowel, or any combination are covered. Includes services related to organ procurement and donor expenses if not covered under another plan. Member must contact medical plan for arrangements.

A. Network includes travel and lodging allowance for the transplant recipient and an immediate family travel companion when the transplant facility is more than fifty (50) miles from the recipient's residence. If the recipient is younger than age nineteen (19) years travel and lodging is covered for both parents. Travel is limited to a ten thousand dollar (\$10,000) maximum per transplant.

(I) Lodging—maximum lodging expenses shall not exceed the per diem rates as established annually by U.S. General Services Administration (GSA) for a specific city or county. Go to [www.gsa.gov](http://www.gsa.gov) for per diem rates.

(II) Travel—IRS standard medical mileage rates (same as flexible spending account (FSA) reimbursement).

(III) Meals—not covered.

B. Non-network. Charges above the maximum for services rendered at a non-network facility are the member's responsibility and do not apply to the member's deductible or out-of-pocket maximum. Travel, lodging, and meals are not covered. Non-network facility charges and payments for transplants are limited to the following maximums:

(I) Stem cell transplant—

(a) Allogeneic related—one hundred fifty-three thousand dollars (\$153,000);

(b) Allogeneic unrelated—one hundred seventy-nine thousand dollars (\$179,000); and

(c) Autologous stem cell transplant—one hundred five thousand dollars (\$105,000);

(II) Heart—one hundred eighty-five thousand dollars (\$185,000);

(III) Heart and lung—two hundred sixty-one thousand three hundred sixty-one dollars (\$261,361);

(IV) Lung—one hundred forty-two thousand eight hundred seventeen dollars (\$142,817);

(V) Kidney—eighty thousand dollars (\$80,000);

(VI) Kidney and pancreas—one hundred thirty thousand dollars (\$130,000);

(VII) Liver—one hundred seventy-five thousand nine hundred dollars (\$175,900);

(VIII) Pancreas—ninety-five thousand dollars (\$95,000); and

(IX) Small bowel—two hundred seventy-five thousand dollars (\$275,000);

43. Urgent care. Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care; and

44. Vision. One (1) routine exam and refraction is covered per calendar year.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-3.060 PPO 600 Plan, PPO 1000 Plan, and HDHP  
Limitations is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 141–142). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

**22 CSR 10-3.075 is amended.**

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 142–145). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: Missouri Consolidated Health Care Plan (MCHCP) received two (2) comments on the proposed amendment.

COMMENT #1: UMR commented that the full address of the External Review organization has changed to include “HHS Federal Request.”

RESPONSE AND EXPLANATION OF CHANGE: Based on this comment, MCHCP has added “HHS Federal Request” to the External Review organization’s address in part (4)(B)2.D.(II).

COMMENT #2: MCHCP staff commented that, under subsection (6)(J), clarification is needed that the once per lifetime of the account appeal that MCHCP may approve when a subscriber missed a deadline does not apply to statutory deadlines and voluntary cancellations.

RESPONSE AND EXPLANATION OF CHANGE: Based on MCHCP staff’s comment, clarification was made under subsection (6)(J), that this guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated.

**22 CSR 10-3.075 Review and Appeals Procedure**

(4) Appeal Process for Medical and Pharmacy Determinations.

(B) Internal Appeals.

1. Eligibility, termination for failure to pay, or rescission. Adverse benefit determinations denying or terminating an individual’s coverage under the plan based on a determination of the individual’s eligibility to participate in the plan or the failure to pay premiums, or any rescission of coverage based on fraud or intentional misrepresentation of a member or authorized representative of a member are appealable exclusively to the Missouri Consolidated Health Care Plan (MCHCP) Board of Trustees (board).

A. The internal review process for appeals relating to eligibility, termination for failure to pay, or rescission shall consist of one (1) level of review by the board.

B. Adverse benefit determination appeals to the board must identify the eligibility, termination, or rescission decision being appealed and the reason the claimant believes the MCHCP staff decision should be overturned. The member should include with his/her appeal any information or documentation to support his/her appeal request.

C. The appeal will be reviewed by the board in a meeting closed pursuant to section 610.021, RSMo, and the appeal will be responded to in writing to the claimant within sixty (60) days from the date the board received the written appeal.

D. Determinations made by the board constitute final internal adverse benefit determinations and are not eligible for external review except as specifically provided in 22 CSR 10-32.075(4)(A)4.

2. Medical and pharmacy services. Members may request internal review of any adverse benefit determination relating to urgent care, pre-service claims, and post-service claims made by the plan’s medical and pharmacy vendors.

A. Appeals of adverse benefit determinations shall be submitted in writing to the vendor that issued the original determination

giving rise to the appeal at the applicable address set forth in this rule.

B. The internal review process for adverse benefit determinations relating to medical services consists of two (2) levels of internal review provided by the medical vendor that issued the adverse benefit determination.

(I) First level appeals must identify the decision being appealed and the reason the member believes the original claim decision should be overturned. The member should include with his/her appeal any additional information or documentation to support the reason the original claim decision should be overturned.

(II) First level appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. First level medical appeals will be responded to in writing to the member within thirty (30) days for post-service claims and fifteen (15) days for pre-service claims from the date the vendor received the first level appeal request.

(III) An expedited appeal of an adverse benefit determination may be requested when a decision is related to a pre-service claim for urgent care. Expedited appeals will be reviewed by the vendor by someone who was not involved in the original decision and will consult with a qualified medical professional if a medical judgment is involved. Expedited appeals will be responded to within seventy-two (72) hours after receiving a request for an expedited review with written confirmation of the decision to the member within three (3) working days of providing notification of the determination.

(IV) Second level appeals must be submitted in writing within sixty (60) days of the date of the first level appeal decision letter that upholds the original adverse benefit determination. Second level appeals should include any additional information or documentation to support the reason the member believes the first level appeal decision should be overturned. Second level appeals will be reviewed by the vendor by someone who was not involved in the original decision or first level appeal and will include consultation with a qualified medical professional if a medical judgment is involved. Second level medical appeals shall be responded to in writing to the member within thirty (30) days for post-service claims and within fifteen (15) days for pre-service claims from the date the vendor received the second level appeal request.

(V) For members with medical coverage through UMR—

(a) First and second level pre-service and concurrent claim appeals must be submitted in writing to—

UMR Appeals  
PO Box 400046  
San Antonio, TX 78229

(b) First and second level post-service appeals must be sent in writing to—

UMR Claims Appeal Unit  
PO Box 30546  
Salt Lake City, UT 84130-0546

(c) Expedited pre-service appeals must be communicated by calling (800) 808-4424, ext. 15227 or by submitting a written fax to (888) 615-6584, Attention: Appeals Unit.

(VI) For members with medical coverage through Coventry Health Care—

(a) First and second level appeals must be submitted in writing to—

Coventry Health Care  
Attn: Appeals Department  
9401 Indian Creek Parkway, Suite 1300  
Overland Park, KS 66210

(b) Expedited appeals must be communicated by calling (913) 202-5000 or by submitting a written fax to (866) 769-2408.

C. The internal review process for adverse benefit determinations relating to pharmacy consists of one (1) level of internal review provided by the pharmacy vendor.

(I) Pharmacy appeals must identify the matter being appealed and should include the member's (and dependent's, if applicable) name, the date the member attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost of the prescription, if applicable, the reason the member believes the claim should be paid, and any other written documentation to support the member's belief that the original decision should be overturned.

(II) All pharmacy appeals must be submitted in writing to—

Express Scripts  
Attn: Pharmacy Appeals—MH3  
Mail Route BL0390  
6625 W. 78th St.  
Bloomington, MN 55439  
or by fax to (877) 852-4070

(III) Pharmacy appeals will be reviewed by someone who was not involved in the original decision and the reviewer will consult with a qualified medical professional if a medical judgment is involved. Pharmacy appeals will be responded to in writing to the member within sixty (60) days for post-service claims and thirty (30) days for pre-service claims from the date the vendor received the appeal request.

D. Members may seek external review only after they have exhausted all applicable levels of internal review or received a final internal adverse benefit determination.

(I) A claimant or authorized representative may file a written request for an external review within four (4) months after the date of receipt of a final internal adverse benefit determination.

(II) The claimant can submit an external review request in writing to—

HHS Federal Request  
MAXIMUS Federal Services  
3750 Monroe Ave., Suite 705  
Pittsford, NY 14534  
or by fax to (888) 866-6190  
or to request a review online at  
<http://www.externalappeal.com/>

(III) The claimant may call the toll-free number (888) 866-6205 with any questions or concerns during the external review process and can submit additional written comments to the external reviewer at the mailing address above.

(IV) The external review decision will be made as expeditiously as possible and within forty-five (45) days after receipt of the request for the external review.

(V) A claimant may make a written or oral request for an expedited external review if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant; or would jeopardize the claimant's ability to regain maximum function; or if the final internal adverse benefit determination involves an admission, availability of care, continued stay, or health care item or service for which the claimant received services, but has not been discharged from a facility.

3. For all internal appeals of adverse benefit determinations, the plan or the vendor reviewing the appeal will provide the member, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan or the vendor in connection with

reviewing the claim or the appeal and will give the member an opportunity to respond to such new evidence or rationale before issuing a final internal adverse determination.

(6) In reviewing appeals, notwithstanding any other rule, the board and/or staff may grant any appeals when there is credible evidence to support approval under the following guidelines:

(J) Once per lifetime of the account, MCHCP may approve an appeal where a subscriber missed a deadline. MCHCP may only approve an appeal under this guideline if the appeal is received within sixty (60) days of the missed deadline. This guideline may not be used to approve an appeal of a voluntary cancellation or an appeal of a deadline that is statutorily mandated; and

(K) MCHCP may approve an appeal to change a subscriber's medical plan vendor prospectively, once per lifetime of the account. This appeal guideline may not be used for a subscriber to change the type of medical plan design elected during open enrollment.

**Title 22—MISSOURI CONSOLIDATED  
HEALTH CARE PLAN  
Division 10—Health Care Plan  
Chapter 3—Public Entity Membership**

**ORDER OF RULEMAKING**

By the authority vested in the Missouri Consolidated Health Care Plan under section 103.059, RSMo 2000, the director amends a rule as follows:

22 CSR 10-3.090 is amended.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on January 2, 2014 (39 MoReg 145–148). Those sections with changes are reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

**SUMMARY OF COMMENTS:** Missouri Consolidated Health Care Plan (MCHCP) received three (3) comments on the proposed amendment.

**COMMENT #1:** MCHCP staff commented that, under part (1)(A)1.I.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.

**RESPONSE AND EXPLANATION OF CHANGE:** Based on MCHCP staff's comment, clarification was made under part (1)(A)1.I.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D<sub>2</sub> or D<sub>3</sub> per dose.

**COMMENT #2:** MCHCP staff commented that under subparagraph (1)(A)3.D., the family out-of-pocket maximum of twelve thousand dollars (\$12,000) for prescription drugs is incorrect. The correct family out-of-pocket maximum is twelve thousand five hundred dollars (\$12,500).

**RESPONSE AND EXPLANATION OF CHANGE:** Based on MCHCP staff's comment, the out-of-pocket maximum was corrected to twelve thousand five hundred dollars (\$12,500).

**COMMENT #3:** MCHCP staff commented that, under part (1)(B)1.E.(I), clarification is needed for the dosage range for preventive Vitamin D coverage.

**RESPONSE AND EXPLANATION OF CHANGE:** Based on MCHCP staff's comment, clarification was made under part (1)(B)1.E.(I), that the dosage range for preventive Vitamin D is at or below 1000 IU of vitamin D<sub>2</sub> or D<sub>3</sub> per dose.

**22 CSR 10-3.090 Pharmacy Benefit Summary**

(1) The pharmacy benefit provides coverage for prescription drugs. Vitamin and nutrient coverage is limited to prenatal agents, therapeutic agents for specific deficiencies and conditions, and hematopoietic agents as prescribed by a physician.

(A) PPO 600 and PPO 1000 Prescription Drug Coverage.

1. Network.

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty-four dollars (\$24) for up to a ninety- (90-) day supply for a generic drug on the formulary; formulary generic birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and one hundred and five dollars (\$105) for up to a ninety- (90-) day supply for a brand drug on the formulary; formulary brand birth control and tobacco cessation prescriptions covered at one hundred percent (100%).

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and three hundred dollars (\$300) for up to a ninety- (90-) day supply for a drug not on the formulary.

D. Home delivery program—

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic copayments: Eight dollars (\$8) for up to a thirty-one- (31-) day supply; sixteen dollars (\$16) for up to a sixty- (60-) day supply; and twenty dollars (\$20) for up to a ninety- (90-) day supply for a generic drug on the formulary.

(b) Brand copayments: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply; seventy dollars (\$70) for up to a sixty- (60-) day supply; and eighty-seven dollars and fifty-cents (\$87.50) for up to a ninety- (90-) day supply for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply; two hundred dollars (\$200) for up to a sixty- (60-) day supply; and two hundred fifty dollars (\$250) for up to a ninety- (90-) day supply for a drug not on the formulary.

(d) A member must choose how maintenance prescription(s) will be filled by notifying the pharmacy benefit manager (PBM) of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM; and

(II) Specialty drugs are covered only through the specialty home delivery network for up to a thirty-one- (31-) day supply. The first specialty prescription order may be filled through a retail pharmacy.

(a) Generic copayments: Eight dollars (\$8) for a generic drug on the formulary list.

(b) Brand copayments: Thirty-five dollars (\$35) for a brand drug on the formulary.

(c) Non-formulary copayments: One hundred dollars (\$100) for a drug not on the formulary; and

E. Only one (1) copayment is charged if a combination of different manufactured dosage amounts must be dispensed in order to fill a prescribed single dosage amount.

F. The copayment for a compound drug is based on the primary drug in the compound. The primary drug in a compound is the most expensive prescription drug in the mix.

G. If the copayment amount is more than the cost of the drug, the member is only responsible for the cost of the drug.

H. If the physician allows for generic substitution and the member chooses a brand-name drug, the member is responsible for the generic copayment and the cost difference between the brand name and generic drug.

I. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older;

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the PBM, less the applicable copayment.

A. Generic copayment: Eight dollars (\$8) for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand copayment: Thirty-five dollars (\$35) for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary copayment: One hundred dollars (\$100) for up to a thirty-one- (31-) day supply for a drug not on the formulary.

3. Out-of-pocket maximum. The out-of-pocket maximum is the maximum amount payable by the participant before the plan begins to pay one hundred percent (100%) of covered charges for the remainder of the calendar year.

A. Network and non-network out-of-pocket maximums are not separate.

B. The family out-of-pocket maximum is an aggregate of applicable charges received by all covered family members of the plan. Any combination of covered family member applicable charges may be used to meet the family out-of-pocket maximum. Applicable charges received by one (1) family member may only meet the individual out-of-pocket maximum amount.

C. Individual—six thousand two hundred fifty dollars (\$6,250).

D. Family—twelve thousand five hundred dollars (\$12,500).

(B) High Deductible Health Plan (HDHP) with Health Savings Account (HSA) Prescription Drug Coverage.

1. Network.

A. Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

B. Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

C. Non-formulary: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

D. Home delivery program.

(I) Maintenance prescriptions may be filled through the home delivery program.

(a) Generic: Ten percent (10%) coinsurance after deductible for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible for a drug not on the formulary.

(d) A member must choose how maintenance prescriptions will be filled by notifying the PBM of his/her decision to fill a maintenance prescription through home delivery or retail pharmacy.

(e) If the member chooses to fill his/her maintenance prescription at a retail pharmacy and the member does not notify the PBM of his/her decision, the first two (2) maintenance prescription orders may be filled by the retail pharmacy. After the first two (2) orders are filled at the retail pharmacy, the member must notify the PBM of his/her decision to continue to fill the maintenance prescription at the retail pharmacy. If a member does not make a decision after the first two (2) orders are filled at the retail pharmacy, s/he will be charged the full discounted cost of the drug until the PBM has been notified of the decision.

(f) Once a member makes his/her delivery decision, the member can modify the decision by contacting the PBM.

(II) Specialty drugs covered only through network home delivery for up to thirty-one- (31-) days.

(a) Generic: Ten percent (10%) coinsurance after deductible has been met for a generic drug on the formulary.

(b) Brand: Twenty percent (20%) coinsurance after deductible has been met for a brand drug on the formulary.

(c) Non-formulary: Forty percent (40%) coinsurance after deductible has been met for a drug not on the formulary; and

E. Prescription drugs and prescribed over-the-counter drugs as recommended by the U.S. Preventive Services Task Force (categories A and B) are covered at one hundred percent (100%). The following are also covered at one hundred percent (100%):

(I) Prescribed Vitamin D for all ages;

(a) The range for preventive Vitamin D is at or below 1000 IU of Vitamin D<sub>2</sub> or D<sub>3</sub> per dose;

(II) Zoster (shingles) vaccine and administration for members age fifty (50) years and older; and

(III) Influenza vaccine and administration as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

(IV) Formulary contraception is covered at one hundred percent (100%). Non-formulary contraception is covered at one hundred percent (100%) when the provider determines a generic is not medically appropriate or a generic version is not available.

2. Non-network: If a member chooses to use a non-network pharmacy, s/he will be required to pay the full cost of the prescription and then file a claim with the PBM. The PBM will reimburse the cost of the drug based on the network discounted amount as determined by the pharmacy benefit manager, less the applicable deductible or coinsurance.

A. Generic: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a generic drug on the formulary.

B. Brand: Forty percent (40%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a brand drug on the formulary.

C. Non-formulary: Fifty percent (50%) coinsurance after deductible has been met for up to a thirty-one- (31-) day supply for a drug not on the formulary.

**STATUTORY LIST OF CONTRACTORS  
BARRED FROM PUBLIC WORKS PROJECTS**

The following is a list of contractor(s) who have been prosecuted and convicted of violating the Missouri Prevailing Wage Law, and whose Notice of Conviction has been filed with the Secretary of State pursuant to Section 290.330, RSMo. Under this statute, no public body shall award a contract for public works to any contractor or subcontractor, or simulation thereof, during the time that such contractor or subcontractor's name appears on this state debarment list maintained by the Secretary of State. In addition, this list includes contractor(s) that have agreed to entry of an injunction permanently prohibiting them and any persons and entities related to them from engaging in, or having any involvement in, any business in Missouri.

**Contractors Convicted of Violations of the Missouri Prevailing Wage Law**

<u>Name of Contractor</u>	<u>Name of Officers</u>	<u>Address</u>	<u>Date of Conviction</u>	<u>Debarment Period</u>
Urban Metropolitan Development, LLC Case No. 12AO-CR01752 (Jasper County Cir. Ct.)		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	08/08/2013	08/08/2013 to 08/08/2014

**Contractors Agreeing to Permanent Prohibition from Engaging In, or Having Any Involvement In, Any Business in Missouri**

<u>Name of Contractor</u>	<u>Name of Officers</u>	<u>Address</u>	<u>Date of Injunction</u>	<u>Debarment Period</u>
Urban Metropolitan Development, LLC		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	09/27/2013	Permanent
Troy Langley		1101 Juniper St., Ste. 925 Atlanta, Georgia 30309	09/27/2013	Permanent

Dated this 17<sup>th</sup> day of March 2014.

  
John E. Lindsey, Division Director

**T**he Secretary of State is required by sections 347.141 and 359.481, RSMo 2000, to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript by email to [dissolutions@sos.mo.gov](mailto:dissolutions@sos.mo.gov).

**Notice of Corporate Dissolution  
To All Creditors of and  
Claimants Against  
HOHCO CORP.**

On March 20, 2014, HOHCO CORP. a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State. Dissolution was effective on December 19, 2013.

Said corporation requests that all persons and organizations who have claims against it present them immediately by letter to the corporation at:

HOHCO CORP.  
Attn: Bradford P. Hohenberg  
38 Berkshire  
St. Louis, MO 63117

Or

Kristy A. Bourgeois, Esq.  
Sandberg Phoenix & von Gontard P.C.  
600 Washington Avenue, 15<sup>th</sup> Floor  
St. Louis, MO 63101

All claims must include the name and address of the claimant; the amount claimed; the basis for the claim; and the date(s) on which the event(s) on which the claim is based occurred.

NOTICE: Because of the dissolution of HOHCO CORP., any claims against it will be barred unless a proceeding to enforce the claim is commenced within two years after the publication date of the two notices authorized by statute, whichever is published last.

**NOTICE OF DISSOLUTION TO ALL CREDITORS OF  
AND CLAIMANTS AGAINST  
M.F.S. FINANCIAL SERVICES, INC.**

Effective March 6, 2014, M.F.S. Financial Services, Inc., a Missouri corporation (the "Corporation"), the principal office of which is located at 1901 Frederick Ave., St. Joseph, Missouri 64501, was voluntarily dissolved.

All claims against the Corporation should be presented in accordance with this notice. Claims should be in writing and sent to the Corporation at the following mailing address: 124 East Third, P.O. Box 567, Cameron, Missouri 64429. The claim must contain: (1) the name, address and telephone number of the claimants; (2) the amount of the claim or other relief demanded; (3) the basis of the claim and any documents related to the claim; and (4) the date(s) as of which the event(s) on which the claim is based occurred. Any and all claims against the Corporation will be barred unless a proceeding to enforce the claim is commenced within two years after the publication of this notice.

**Notice of Corporate Dissolution  
To All Creditors of and  
Claimants Against  
FIDELITY MORTGAGE CORPORATION**

On March 21, 2014, FIDELITY MORTGAGE CORPORATION, a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State. Dissolution was effective on January 2, 2014.

Said corporation requests that all persons and organizations who have claims against it present them immediately by letter to the corporation at:

FIDELITY MORTGAGE CORPORATION  
Attn: Dale Cottrell, Registered Agent  
318 W. Main Street  
Sullivan, MO 63080

Or

Mara J. Lahnar, Esq.  
Sandberg Phoenix & von Gontard P.C.  
600 Washington Avenue, 15<sup>th</sup> Floor  
St. Louis, MO 63101

All claims must include the name and address of the claimant; the amount claimed; the basis for the claim; and the date(s) on which the event(s) on which the claim is based occurred.

NOTICE: Because of the dissolution of FIDELITY MORTGAGE CORPORATION, any claims against it will be barred unless a proceeding to enforce the claim is commenced within two years after the publication date of the two notices authorized by statute, whichever is published last.



# Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—37 (2012) and 38 (2013). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RAN indicates a rule action notice, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
1 CSR 10	<b>OFFICE OF ADMINISTRATION</b> State Officials' Salary Compensation Schedule				37 MoReg 1859 38 MoReg 2053
<b>DEPARTMENT OF AGRICULTURE</b>					
2 CSR 30-10.010	Animal Health		39 MoReg 68	39 MoReg 871	
2 CSR 80-2.050	State Milk Board		38 MoReg 1363	39 MoReg 253	
2 CSR 80-5.010	State Milk Board		38 MoReg 1363	39 MoReg 253	
2 CSR 90-10	Weights and Measures				38 MoReg 1241
2 CSR 90-30.040	Weights and Measures		38 MoReg 1099	39 MoReg 871	
<b>DEPARTMENT OF CONSERVATION</b>					
3 CSR 10-3.010	Conservation Commission		38 MoReg 1742	39 MoReg 253	
3 CSR 10-4.111	Conservation Commission		39 MoReg 849		
3 CSR 10-4.130	Conservation Commission		38 MoReg 1742	39 MoReg 253	
3 CSR 10-5.430	Conservation Commission		38 MoReg 1742	39 MoReg 253	
3 CSR 10-6.510	Conservation Commission		38 MoReg 1742	39 MoReg 254	
3 CSR 10-6.545	Conservation Commission		38 MoReg 1743	39 MoReg 255	
3 CSR 10-6.550	Conservation Commission		38 MoReg 1743	39 MoReg 255	
			39 MoReg 849		
3 CSR 10-7.410	Conservation Commission		38 MoReg 1744	39 MoReg 255	
3 CSR 10-7.431	Conservation Commission		38 MoReg 1744	39 MoReg 255	
3 CSR 10-7.433	Conservation Commission		38 MoReg 1744	39 MoReg 255	
3 CSR 10-7.440	Conservation Commission		38 MoReg 1745	39 MoReg 255	
3 CSR 10-7.455	Conservation Commission				39 MoReg 403
3 CSR 10-9.105	Conservation Commission		38 MoReg 1745	39 MoReg 256	
3 CSR 10-9.110	Conservation Commission		38 MoReg 1747	39 MoReg 256	
3 CSR 10-9.442	Conservation Commission		38 MoReg 1750	39 MoReg 256	
3 CSR 10-10.705	Conservation Commission		38 MoReg 1750	39 MoReg 256	
3 CSR 10-10.735	Conservation Commission		39 MoReg 849		
3 CSR 10-10.744	Conservation Commission		38 MoReg 1752	39 MoReg 256	
3 CSR 10-11.115	Conservation Commission		39 MoReg 850		
3 CSR 10-11.130	Conservation Commission		38 MoReg 1752	39 MoReg 256	
3 CSR 10-11.180	Conservation Commission		38 MoReg 1752	39 MoReg 257	
3 CSR 10-11.184	Conservation Commission		38 MoReg 1753	39 MoReg 257	
3 CSR 10-11.185	Conservation Commission		38 MoReg 1753	39 MoReg 257	
3 CSR 10-11.205	Conservation Commission		38 MoReg 1754	39 MoReg 257	
			39 MoReg 850		
3 CSR 10-11.210	Conservation Commission		39 MoReg 851		
3 CSR 10-11.215	Conservation Commission		39 MoReg 851		
3 CSR 10-12.110	Conservation Commission		38 MoReg 1754	39 MoReg 257	
			39 MoReg 852		
3 CSR 10-12.115	Conservation Commission		38 MoReg 1755	39 MoReg 257	
3 CSR 10-12.125	Conservation Commission		38 MoReg 1756	39 MoReg 258	
3 CSR 10-12.135	Conservation Commission		38 MoReg 1756	39 MoReg 258	
3 CSR 10-12.140	Conservation Commission		38 MoReg 1757	39 MoReg 258	
			N.A.	39 MoReg 874	
			39 MoReg 852		
3 CSR 10-12.145	Conservation Commission		38 MoReg 1757	39 MoReg 258	
			N.A.	39 MoReg 874	
			39 MoReg 852		
<b>DEPARTMENT OF ECONOMIC DEVELOPMENT</b>					
4 CSR 85-8.010	Division of Business and Community Services	38 MoReg 1925 39 MoReg 489T			
4 CSR 85-8.011	Division of Business and Community Services	This Issue	39 MoReg 591		
4 CSR 85-8.020	Division of Business and Community Services	38 MoReg 1934 39 MoReg 489T			
4 CSR 85-8.021	Division of Business and Community Services	This Issue	39 MoReg 600		
4 CSR 85-8.030	Division of Business and Community Services	38 MoReg 1934 39 MoReg 489T			
4 CSR 85-9.010	Division of Business and Community Services	38 MoReg 1935 39 MoReg 489T			
4 CSR 85-9.011	Division of Business and Community Services	This Issue	39 MoReg 600		
4 CSR 85-9.020	Division of Business and Community Services	38 MoReg 1936 39 MoReg 489T			

Rule Number	Agency	Emergency	Proposed	Order	In Addition
4 CSR 85-9.021	Division of Business and Community Services	This Issue	39 MoReg 602		
4 CSR 85-9.030	Division of Business and Community Services	38 MoReg 1937 39 MoReg 490T			
4 CSR 85-9.031	Division of Business and Community Services	This Issue	39 MoReg 603		
4 CSR 85-9.035	Division of Business and Community Services	This Issue	39 MoReg 613		
4 CSR 85-9.040	Division of Business and Community Services	38 MoReg 1947 39 MoReg 490T			
4 CSR 85-9.041	Division of Business and Community Services	This Issue	39 MoReg 617		
4 CSR 85-9.050	Division of Business and Community Services	38 MoReg 1954 39 MoReg 490T			
4 CSR 85-9.051	Division of Business and Community Services	This Issue	39 MoReg 621		
4 CSR 85-10.010	Division of Business and Community Services		39 MoReg 721		
4 CSR 85-10.020	Division of Business and Community Services		39 MoReg 723		
4 CSR 85-10.030	Division of Business and Community Services		39 MoReg 724		
4 CSR 85-10.040	Division of Business and Community Services		39 MoReg 725		
4 CSR 85-10.050	Division of Business and Community Services		39 MoReg 726		
4 CSR 85-10.060	Division of Business and Community Services		39 MoReg 728		
4 CSR 240-2.090	Public Service Commission		39 MoReg 630		
4 CSR 240-3.570	Public Service Commission		38 MoReg 1461R	39 MoReg 660R	
4 CSR 240-31.010	Public Service Commission		38 MoReg 1461	39 MoReg 661	
4 CSR 240-31.020	Public Service Commission		38 MoReg 1463	39 MoReg 664	
4 CSR 240-31.030	Public Service Commission		38 MoReg 1464	39 MoReg 666	
4 CSR 240-31.040	Public Service Commission		38 MoReg 1465R	39 MoReg 667W	
4 CSR 240-31.050	Public Service Commission		38 MoReg 1465R	39 MoReg 669R	
4 CSR 240-31.060	Public Service Commission		38 MoReg 1466	39 MoReg 670	
4 CSR 240-31.065	Public Service Commission		38 MoReg 1467R	39 MoReg 672R	
4 CSR 240-31.070	Public Service Commission		38 MoReg 1468R	39 MoReg 673R	
4 CSR 240-31.080	Public Service Commission		38 MoReg 1468R	39 MoReg 674R	
4 CSR 240-31.090	Public Service Commission		38 MoReg 1468	39 MoReg 676	
4 CSR 240-31.100	Public Service Commission		38 MoReg 1469R	39 MoReg 677W	
4 CSR 240-31.110	Public Service Commission		38 MoReg 1469	39 MoReg 678	
4 CSR 240-31.120	Public Service Commission		38 MoReg 1470	39 MoReg 680	
4 CSR 240-31.130	Public Service Commission		38 MoReg 1472	39 MoReg 683	

**DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION**

5 CSR 10-2.010	Commissioner of Education	38 MoReg 1966	39 MoReg 785
5 CSR 10-2.020	Commissioner of Education	38 MoReg 1971	39 MoReg 785
5 CSR 10-2.030	Commissioner of Education	38 MoReg 1971	39 MoReg 786
5 CSR 20-100.170	Division of Learning Services	38 MoReg 1972R	This IssueR
5 CSR 20-100.255	Division of Learning Services	37 MoReg 1571	38 MoReg 520F
5 CSR 20-100.265	Division of Learning Services	38 MoReg 1758	39 MoReg 786
5 CSR 20-200.290	Division of Learning Services	38 MoReg 1762	39 MoReg 787
5 CSR 20-200.300	Division of Learning Services	38 MoReg 1762	39 MoReg 788
5 CSR 20-400.120	Division of Learning Services	39 MoReg 191R	
5 CSR 20-400.130	Division of Learning Services	39 MoReg 191R	
5 CSR 20-400.140	Division of Learning Services	39 MoReg 192R	
5 CSR 20-400.375	Division of Learning Services	38 MoReg 1972	39 MoReg 737
5 CSR 20-400.500	Division of Learning Services	38 MoReg 1976	39 MoReg 792
5 CSR 20-400.510	Division of Learning Services	38 MoReg 1977	39 MoReg 793
5 CSR 20-400.520	Division of Learning Services	38 MoReg 1978	39 MoReg 795
5 CSR 20-400.530	Division of Learning Services	38 MoReg 1979	39 MoReg 797
5 CSR 20-400.540	Division of Learning Services	38 MoReg 1981	39 MoReg 798
5 CSR 20-400.550	Division of Learning Services	38 MoReg 1985	39 MoReg 800
5 CSR 20-400.560	Division of Learning Services	38 MoReg 1987	39 MoReg 803
5 CSR 20-400.570	Division of Learning Services	38 MoReg 1992	39 MoReg 809
5 CSR 20-400.580	Division of Learning Services	38 MoReg 1992	39 MoReg 809
5 CSR 20-400.590	Division of Learning Services	38 MoReg 1993	39 MoReg 810
5 CSR 20-400.600	Division of Learning Services	38 MoReg 1994	39 MoReg 810
5 CSR 20-400.610	Division of Learning Services	38 MoReg 1994	39 MoReg 811
5 CSR 20-400.620	Division of Learning Services	38 MoReg 1998	39 MoReg 814
5 CSR 20-400.630	Division of Learning Services	38 MoReg 1998	39 MoReg 815
5 CSR 20-400.640	Division of Learning Services	38 MoReg 1999	39 MoReg 815
5 CSR 20-400.650	Division of Learning Services	38 MoReg 2002	39 MoReg 818
5 CSR 20-400.660	Division of Learning Services	38 MoReg 2003	39 MoReg 819
5 CSR 20-400.670	Division of Learning Services	38 MoReg 2005	39 MoReg 821
5 CSR 20-400.680	Division of Learning Services	38 MoReg 2006	39 MoReg 823
5 CSR 20-400.690	Division of Learning Services	38 MoReg 2007	39 MoReg 823
5 CSR 20-400.700	Division of Learning Services	38 MoReg 2008	39 MoReg 824
5 CSR 20-500.120	Division of Learning Services	38 MoReg 1764	39 MoReg 824
5 CSR 20-500.130	Division of Learning Services	39 MoReg 630	
5 CSR 20-500.140	Division of Learning Services	39 MoReg 631	
5 CSR 20-500.150	Division of Learning Services	39 MoReg 632	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
5 CSR 20-500.160	Division of Learning Services		39 MoReg 633		
5 CSR 20-500.170	Division of Learning Services		39 MoReg 633		
5 CSR 20-500.180	Division of Learning Services		39 MoReg 634		
5 CSR 20-500.190	Division of Learning Services		39 MoReg 634		
5 CSR 20-500.200	Division of Learning Services		39 MoReg 635		
5 CSR 100-200.010	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 636		
5 CSR 100-200.030	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 636R		
5 CSR 100-200.035	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 637		
5 CSR 100-200.040	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 639		
5 CSR 100-200.045	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 639		
5 CSR 100-200.050	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 640		
5 CSR 100-200.060	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 642		
5 CSR 100-200.070	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 642		
5 CSR 100-200.075	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 643R		
5 CSR 100-200.130	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 643		
5 CSR 100-200.150	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 645		
5 CSR 100-200.170	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 648		
5 CSR 100-200.210	Missouri Commission for the Deaf and Hard of Hearing		39 MoReg 651		
<b>DEPARTMENT OF TRANSPORTATION</b>					
7 CSR 10-1.010	Missouri Highways and Transportation Commission		39 MoReg 729R 39 MoReg 729		
7 CSR 10-6.010	Missouri Highways and Transportation Commission		38 MoReg 1860	39 MoReg 874	
7 CSR 10-6.015	Missouri Highways and Transportation Commission		38 MoReg 1861	39 MoReg 874	
7 CSR 10-6.020	Missouri Highways and Transportation Commission		38 MoReg 1862	39 MoReg 875	
7 CSR 10-6.030	Missouri Highways and Transportation Commission		38 MoReg 1863	39 MoReg 875	
7 CSR 10-6.040	Missouri Highways and Transportation Commission		38 MoReg 1864	39 MoReg 875	
7 CSR 10-6.050	Missouri Highways and Transportation Commission		38 MoReg 1870	39 MoReg 875	
7 CSR 10-6.060	Missouri Highways and Transportation Commission		38 MoReg 1870	39 MoReg 876	
7 CSR 10-6.070	Missouri Highways and Transportation Commission		38 MoReg 1871	39 MoReg 876	
7 CSR 10-6.080	Missouri Highways and Transportation Commission		38 MoReg 1873	39 MoReg 876	
7 CSR 10-6.085	Missouri Highways and Transportation Commission		38 MoReg 1874	39 MoReg 876	
7 CSR 10-6.090	Missouri Highways and Transportation Commission		38 MoReg 1876	39 MoReg 876	
7 CSR 10-12.010	Missouri Highways and Transportation Commission		39 MoReg 493		
7 CSR 10-12.020	Missouri Highways and Transportation Commission		39 MoReg 493		
7 CSR 10-12.030	Missouri Highways and Transportation Commission		39 MoReg 494		
7 CSR 10-25.010	Missouri Highways and Transportation Commission				39 MoReg 691 39 MoReg 692
<b>DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS</b>					
8 CSR 10-3.085	Division of Employment Security		38 MoReg 1876	39 MoReg 689	
8 CSR 10-3.150	Division of Employment Security	38 MoReg 1515	38 MoReg 1532	39 MoReg 258	
8 CSR 10-4.020	Division of Employment Security		38 MoReg 1533	39 MoReg 258	
8 CSR 10-4.210	Division of Employment Security	38 MoReg 1516	38 MoReg 1533	39 MoReg 259	
8 CSR 50-2.030	Division of Workers' Compensation		38 MoReg 2087	39 MoReg 876	
<b>DEPARTMENT OF MENTAL HEALTH</b>					
9 CSR 30-2.010	Certification Standards		39 MoReg 438		
<b>DEPARTMENT OF NATURAL RESOURCES</b>					
10 CSR 10-3.010	Air Conservation Commission		38 MoReg 1100R	38 MoReg 2045R	
10 CSR 10-5.220	Air Conservation Commission		39 MoReg 769		
10 CSR 10-5.240	Air Conservation Commission		38 MoReg 1877R		
10 CSR 10-6.010	Air Conservation Commission		38 MoReg 2089		
10 CSR 10-6.040	Air Conservation Commission		39 MoReg 853		
10 CSR 10-6.165	Air Conservation Commission		39 MoReg 732		
10 CSR 10-6.200	Air Conservation Commission		38 MoReg 1382 38 MoReg 2008		
10 CSR 20-6.011	Clean Water Commission		38 MoReg 1534	39 MoReg 877	
10 CSR 20-7.015	Clean Water Commission		38 MoReg 913	39 MoReg 259	
10 CSR 20-7.031	Clean Water Commission		38 MoReg 939	39 MoReg 291	
10 CSR 25	Hazardous Waste Management Commission				39 MoReg 461RUC
10 CSR 40-6.030	Land Reclamation Commission		38 MoReg 1298	38 MoReg 2045	
10 CSR 40-6.070	Land Reclamation Commission		38 MoReg 1299	38 MoReg 2045	
10 CSR 40-6.100	Land Reclamation Commission		38 MoReg 1300	38 MoReg 2045	
10 CSR 40-8.030	Land Reclamation Commission		38 MoReg 1301	38 MoReg 2046	
10 CSR 40-8.040	Land Reclamation Commission		38 MoReg 1301	38 MoReg 2046	
10 CSR 140-2	Division of Energy				38 MoReg 432 38 MoReg 1431
<b>DEPARTMENT OF PUBLIC SAFETY</b>					
11 CSR 45-1.090	Missouri Gaming Commission		39 MoReg 651		
11 CSR 45-4.010	Missouri Gaming Commission		39 MoReg 192		
11 CSR 45-4.020	Missouri Gaming Commission		39 MoReg 192		
11 CSR 45-4.030	Missouri Gaming Commission		39 MoReg 196		
11 CSR 45-4.055	Missouri Gaming Commission		39 MoReg 196		
11 CSR 45-4.190	Missouri Gaming Commission		39 MoReg 196		
11 CSR 45-4.200	Missouri Gaming Commission		39 MoReg 197		
11 CSR 45-4.205	Missouri Gaming Commission		39 MoReg 198R		
11 CSR 45-4.230	Missouri Gaming Commission		39 MoReg 652		
11 CSR 45-4.260	Missouri Gaming Commission		39 MoReg 198		
11 CSR 45-4.380	Missouri Gaming Commission		39 MoReg 201		
11 CSR 45-4.390	Missouri Gaming Commission		39 MoReg 201		
11 CSR 45-4.400	Missouri Gaming Commission		39 MoReg 203		
11 CSR 45-4.410	Missouri Gaming Commission		39 MoReg 203		
11 CSR 45-4.420	Missouri Gaming Commission		39 MoReg 204		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
11 CSR 45-5.190	Missouri Gaming Commission		39 MoReg 657		
11 CSR 45-5.225	Missouri Gaming Commission		39 MoReg 658		
11 CSR 45-5.237	Missouri Gaming Commission		38 MoReg 2019	This Issue	
11 CSR 45-7.170	Missouri Gaming Commission		39 MoReg 204		
11 CSR 45-9.111	Missouri Gaming Commission		38 MoReg 2020	This Issue	
11 CSR 45-9.113	Missouri Gaming Commission		39 MoReg 204		
11 CSR 45-9.118	Missouri Gaming Commission		39 MoReg 205		
11 CSR 45-9.119	Missouri Gaming Commission		38 MoReg 2022	This Issue	
11 CSR 45-10.020	Missouri Gaming Commission		39 MoReg 205		
11 CSR 45-13.030	Missouri Gaming Commission		39 MoReg 205		
<b>DEPARTMENT OF REVENUE</b>					
12 CSR 10-23.500	Director of Revenue	38 MoReg 1520	38 MoReg 1550	39 MoReg 164	
12 CSR 10-41.010	Director of Revenue	38 MoReg 1965	38 MoReg 2022	39 MoReg 689	
12 CSR 10-109.050	Director of Revenue		39 MoReg 495		
12 CSR 30-4.010	State Tax Commission		39 MoReg 438		
<b>DEPARTMENT OF SOCIAL SERVICES</b>					
13 CSR 35-36.010	Children's Division		38 MoReg 2025	39 MoReg 738	
13 CSR 35-71.010	Children's Division		39 MoReg 206		
13 CSR 35-71.020	Children's Division		39 MoReg 207		
13 CSR 35-71.025	Children's Division		39 MoReg 209		
13 CSR 35-71.030	Children's Division		39 MoReg 210		
13 CSR 35-71.035	Children's Division		39 MoReg 213		
13 CSR 35-71.040	Children's Division		39 MoReg 213		
13 CSR 35-71.045	Children's Division		39 MoReg 214		
13 CSR 35-71.050	Children's Division		39 MoReg 216		
13 CSR 35-71.060	Children's Division		39 MoReg 218		
13 CSR 35-71.070	Children's Division		39 MoReg 220		
13 CSR 35-71.075	Children's Division		39 MoReg 225		
13 CSR 35-71.080	Children's Division		39 MoReg 226		
13 CSR 35-71.090	Children's Division		39 MoReg 228		
13 CSR 35-71.100	Children's Division		39 MoReg 228		
13 CSR 35-71.110	Children's Division		39 MoReg 230		
13 CSR 35-71.120	Children's Division		39 MoReg 231		
13 CSR 35-71.130	Children's Division		39 MoReg 231		
13 CSR 35-71.140	Children's Division		39 MoReg 233		
13 CSR 40-2.010	Family Support Division	39 MoReg 431	38 MoReg 1393	39 MoReg 164	
13 CSR 40-7.010	Family Support Division	39 MoReg 432	38 MoReg 1394	39 MoReg 164	
13 CSR 40-7.015	Family Support Division	39 MoReg 433	38 MoReg 1395	39 MoReg 164	
13 CSR 40-7.020	Family Support Division	39 MoReg 434	38 MoReg 1396	39 MoReg 165	
13 CSR 40-7.030	Family Support Division	39 MoReg 435	38 MoReg 1396	39 MoReg 165	
13 CSR 40-7.040	Family Support Division	39 MoReg 436	38 MoReg 1397	39 MoReg 165	
13 CSR 40-24.080	Family Support Division		38 MoReg 2026	This Issue	
13 CSR 40-24.090	Family Support Division		38 MoReg 2032	This Issue	
13 CSR 40-24.100	Family Support Division		38 MoReg 2035	This Issue	
13 CSR 40-100.040	Family Support Division	38 MoReg 1601	38 MoReg 1617	39 MoReg 398	
13 CSR 65-2.010	Missouri Medicaid Audit and Compliance		39 MoReg 235		
13 CSR 65-2.020	Missouri Medicaid Audit and Compliance		39 MoReg 238		
13 CSR 65-2.030	Missouri Medicaid Audit and Compliance		39 MoReg 245		
13 CSR 70-1.020	MO HealthNet Division		39 MoReg 854		
13 CSR 70-2.200	MO HealthNet Division		39 MoReg 856		
13 CSR 70-3.030	MO HealthNet Division		38 MoReg 1617	39 MoReg 690	
13 CSR 70-3.200	MO HealthNet Division		38 MoReg 1877	39 MoReg 738	
13 CSR 70-3.250	MO HealthNet Division		39 MoReg 858		
13 CSR 70-10.015	MO HealthNet Division		38 MoReg 1218	38 MoReg 2046	
13 CSR 70-10.016	MO HealthNet Division	39 MoReg 765	38 MoReg 2039	39 MoReg 824	
13 CSR 70-10.030	MO HealthNet Division		39 MoReg 245	This Issue	
13 CSR 70-10.160	MO HealthNet Division	38 MoReg 1520	38 MoReg 1221	38 MoReg 2046	
13 CSR 70-15.010	MO HealthNet Division	38 MoReg 1215	38 MoReg 1222	38 MoReg 2046	
13 CSR 70-15.110	MO HealthNet Division	38 MoReg 1216	38 MoReg 1226	38 MoReg 2046	
13 CSR 70-15.160	MO HealthNet Division		38 MoReg 1232	38 MoReg 2047	
13 CSR 70-25.120	MO HealthNet Division		38 MoReg 1880	39 MoReg 738	
13 CSR 70-40.010	MO HealthNet Division		38 MoReg 1882	39 MoReg 738	
13 CSR 70-45.010	MO HealthNet Division		38 MoReg 1883	39 MoReg 738	
13 CSR 70-98.020	MO HealthNet Division		38 MoReg 1884	39 MoReg 690	
<b>DEPARTMENT OF CORRECTIONS</b>					
14 CSR 80-5.010	State Board of Probation and Parole		38 MoReg 2043	39 MoReg 739	
14 CSR 80-5.020	State Board of Probation and Parole		38 MoReg 2043	39 MoReg 739	
<b>ELECTED OFFICIALS</b>					
15 CSR 30-15.010	Secretary of State		38 MoReg 1553	39 MoReg 398	
15 CSR 30-15.020	Secretary of State		38 MoReg 1553	39 MoReg 398	
15 CSR 30-50.010	Secretary of State		38 MoReg 835		
			39 MoReg 249		
15 CSR 30-50.040	Secretary of State		38 MoReg 835		
			39 MoReg 249		
15 CSR 30-52.015	Secretary of State		38 MoReg 836		
			39 MoReg 250		
15 CSR 30-52.030	Secretary of State		38 MoReg 836		
			39 MoReg 250		
15 CSR 30-52.275	Secretary of State		38 MoReg 837		
			39 MoReg 251		

Rule Number	Agency	Emergency	Proposed	Order	In Addition
15 CSR 30-54.010	Secretary of State		38 MoReg 837 39 MoReg 251		
15 CSR 30-54.070	Secretary of State		38 MoReg 837 39 MoReg 251		
15 CSR 30-54.150	Secretary of State		38 MoReg 838 39 MoReg 252		
15 CSR 30-90.010	Secretary of State	38 MoReg 1522	38 MoReg 1554	39 MoReg 398	
15 CSR 30-90.090	Secretary of State	38 MoReg 1522	38 MoReg 1554	39 MoReg 398	
15 CSR 30-90.170	Secretary of State	38 MoReg 1523	38 MoReg 1555	39 MoReg 398	
<b>RETIREMENT SYSTEMS</b>					
16 CSR 10-1.040	The Public School Retirement System of Missouri		38 MoReg 1232	38 MoReg 2047	
16 CSR 10-3.010	The Public School Retirement System of Missouri		38 MoReg 1233 39 MoReg 497	38 MoReg 2047	
16 CSR 10-4.005	The Public School Retirement System of Missouri		38 MoReg 1234	38 MoReg 2047	
16 CSR 10-5.010	The Public School Retirement System of Missouri		38 MoReg 1235	38 MoReg 2047	
16 CSR 10-6.020	The Public School Retirement System of Missouri		38 MoReg 1235 39 MoReg 497	38 MoReg 2048	
16 CSR 10-6.060	The Public School Retirement System of Missouri		38 MoReg 1237	38 MoReg 2048	
16 CSR 20-2.060	Missouri Local Government Employees' Retirement System (LAGERS)	39 MoReg 436	39 MoReg 441		
<b>DEPARTMENT OF HEALTH AND SENIOR SERVICES</b>					
19 CSR 10-33.010	Office of the Director		39 MoReg 732R 39 MoReg 733		
19 CSR 25-30.031	State Public Health Laboratory	38 MoReg 1602	38 MoReg 1623	39 MoReg 399	
19 CSR 25-30.050	State Public Health Laboratory	38 MoReg 1604	38 MoReg 1625	39 MoReg 399	
19 CSR 25-30.051	State Public Health Laboratory		38 MoReg 1625	39 MoReg 399	
19 CSR 25-30.060	State Public Health Laboratory	38 MoReg 1604	38 MoReg 1626	39 MoReg 399	
19 CSR 30-20.070	Division of Regulation and Licensure		39 MoReg 441		
19 CSR 30-20.088	Division of Regulation and Licensure		39 MoReg 443		
19 CSR 30-20.090	Division of Regulation and Licensure		39 MoReg 443		
19 CSR 30-20.094	Division of Regulation and Licensure		39 MoReg 444		
19 CSR 30-20.096	Division of Regulation and Licensure		39 MoReg 446		
19 CSR 30-20.098	Division of Regulation and Licensure		38 MoReg 1166	38 MoReg 2093	
19 CSR 30-20.104	Division of Regulation and Licensure		39 MoReg 447		
19 CSR 30-20.108	Division of Regulation and Licensure		39 MoReg 448		
19 CSR 30-20.110	Division of Regulation and Licensure		38 MoReg 1167	38 MoReg 2093	
19 CSR 30-20.112	Division of Regulation and Licensure		38 MoReg 1168	38 MoReg 2093	
19 CSR 30-20.114	Division of Regulation and Licensure		38 MoReg 1168	38 MoReg 2094	
19 CSR 30-20.116	Division of Regulation and Licensure		39 MoReg 449		
19 CSR 30-20.118	Division of Regulation and Licensure		38 MoReg 1170	38 MoReg 2094	
19 CSR 30-20.122	Division of Regulation and Licensure		38 MoReg 1170R	38 MoReg 2094R	
19 CSR 30-20.124	Division of Regulation and Licensure		38 MoReg 1171	38 MoReg 2094	
19 CSR 30-20.125	Division of Regulation and Licensure		39 MoReg 450		
19 CSR 30-20.136	Division of Regulation and Licensure		39 MoReg 451		
19 CSR 30-20.138	Division of Regulation and Licensure		39 MoReg 452		
19 CSR 30-20.140	Division of Regulation and Licensure		39 MoReg 452		
19 CSR 30-20.142	Division of Regulation and Licensure		38 MoReg 1171	38 MoReg 2095	
19 CSR 30-22.020	Division of Regulation and Licensure		39 MoReg 453R		
19 CSR 30-22.030	Division of Regulation and Licensure		39 MoReg 453R		
19 CSR 30-24.040	Division of Regulation and Licensure		39 MoReg 454R		
19 CSR 60-50	Missouri Health Facilities Review Committee				39 MoReg 740
19 CSR 60-50.400	Missouri Health Facilities Review Committee		39 MoReg 861		
19 CSR 60-50.410	Missouri Health Facilities Review Committee		39 MoReg 863		
19 CSR 60-50.415	Missouri Health Facilities Review Committee		39 MoReg 863		
19 CSR 60-50.420	Missouri Health Facilities Review Committee		39 MoReg 866		
19 CSR 60-50.430	Missouri Health Facilities Review Committee		39 MoReg 866		
19 CSR 60-50.440	Missouri Health Facilities Review Committee		39 MoReg 867		
19 CSR 60-50.450	Missouri Health Facilities Review Committee		39 MoReg 868		
19 CSR 60-50.600	Missouri Health Facilities Review Committee		39 MoReg 868		
19 CSR 60-50.700	Missouri Health Facilities Review Committee		39 MoReg 868		
<b>DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION</b>					
20 CSR	Applied Behavior Analysis Maximum Benefit				38 MoReg 432 39 MoReg 692
20 CSR	Construction Claims Binding Arbitration Cap				39 MoReg 167
20 CSR	Sovereign Immunity Limits				39 MoReg 167
20 CSR	State Legal Expense Fund Cap				39 MoReg 167
20 CSR 400-2.160	Life, Annuities and Health		38 MoReg 1555	39 MoReg 399	
20 CSR 400-5.600	Life, Annuities and Health		38 MoReg 1885	39 MoReg 690	
20 CSR 1140-30.240	Division of Finance		38 MoReg 1628	39 MoReg 739	
20 CSR 2030-2.040	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		38 MoReg 1487	39 MoReg 400	
20 CSR 2030-2.050	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		38 MoReg 1487	39 MoReg 400	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
20 CSR 2030-2.060	Missouri Board for Architects, Professional Engineers, Professional Land Surveyors, and Landscape Architects		38 MoReg 1487	39 MoReg 400W	
20 CSR 2063-6.005	Behavior Analyst Advisory Board		38 MoReg 1631	39 MoReg 690	
20 CSR 2085-8.070	Board of Cosmetology and Barber Examiners		39 MoReg 68		
20 CSR 2085-12.010	Board of Cosmetology and Barber Examiners		38 MoReg 1637	39 MoReg 400	
20 CSR 2085-12.020	Board of Cosmetology and Barber Examiners		38 MoReg 1637	39 MoReg 401	
20 CSR 2085-13.070	Board of Cosmetology and Barber Examiners		38 MoReg 1638	39 MoReg 401	
20 CSR 2145-1.040	Missouri Board of Geologist Registration		38 MoReg 1114	38 MoReg 2048	
20 CSR 2145-2.020	Missouri Board of Geologist Registration		38 MoReg 1116	38 MoReg 2048	
20 CSR 2145-2.030	Missouri Board of Geologist Registration		38 MoReg 1116	38 MoReg 2048	
20 CSR 2145-2.065	Missouri Board of Geologist Registration		38 MoReg 1117	38 MoReg 2049	
20 CSR 2145-2.080	Missouri Board of Geologist Registration		38 MoReg 1120	38 MoReg 2049	
20 CSR 2165-1.020	Board of Examiners for Hearing Instrument Specialists		38 MoReg 1638	39 MoReg 401	
20 CSR 2165-2.030	Board of Examiners for Hearing Instrument Specialists		38 MoReg 1641	39 MoReg 401	
20 CSR 2200-1.010	State Board of Nursing		38 MoReg 1641	39 MoReg 401	
20 CSR 2200-4.020	State Board of Nursing		38 MoReg 1642	39 MoReg 402	
20 CSR 2200-4.030	State Board of Nursing		38 MoReg 1556	39 MoReg 402	
20 CSR 2205-3.030	Missouri Board of Occupational Therapy		38 MoReg 1303	38 MoReg 2049	
			39 MoReg 454		
20 CSR 2210-2.030	State Board of Optometry		39 MoReg 73	39 MoReg 889	
20 CSR 2220-2.950	State Board of Pharmacy		38 MoReg 1237	38 MoReg 2049	
20 CSR 2231-2.010	Division of Professional Registration		38 MoReg 1643	39 MoReg 402	
			39 MoReg 498		
20 CSR 2232-1.040	Missouri State Committee of Interpreters		38 MoReg 1409	38 MoReg 2095	
20 CSR 2232-2.010	Missouri State Committee of Interpreters		38 MoReg 1412	38 MoReg 2096	
20 CSR 2232-2.020	Missouri State Committee of Interpreters		38 MoReg 1416	38 MoReg 2096	
20 CSR 2232-2.030	Missouri State Committee of Interpreters		38 MoReg 1420	38 MoReg 2096	
20 CSR 2235-1.020	State Committee of Psychologists		38 MoReg 1175	38 MoReg 2050	
20 CSR 2235-1.025	State Committee of Psychologists		38 MoReg 1179	38 MoReg 2050	
20 CSR 2235-1.026	State Committee of Psychologists		38 MoReg 1179	38 MoReg 2050	
20 CSR 2235-1.030	State Committee of Psychologists		38 MoReg 1179R	38 MoReg 2051R	
			38 MoReg 1180	38 MoReg 2051	
20 CSR 2235-2.060	State Committee of Psychologists		38 MoReg 1182	38 MoReg 2051	
20 CSR 2235-2.065	State Committee of Psychologists		38 MoReg 1182	38 MoReg 2051	
20 CSR 2245-1.010	Real Estate Appraisers		38 MoReg 1303	38 MoReg 2052	
20 CSR 2245-3.005	Real Estate Appraisers		38 MoReg 1304	38 MoReg 2052	
20 CSR 2245-3.010	Real Estate Appraisers		38 MoReg 1304	38 MoReg 2052	
20 CSR 2245-6.040	Real Estate Appraisers		38 MoReg 1305	38 MoReg 2052	
20 CSR 2245-8.010	Real Estate Appraisers		38 MoReg 1305	38 MoReg 2052	
20 CSR 2245-8.030	Real Estate Appraisers		38 MoReg 1306	38 MoReg 2052	
<b>MISSOURI CONSOLIDATED HEALTH CARE PLAN</b>					
22 CSR 10-1.010	Health Care Plan		39 MoReg 73	This Issue	
22 CSR 10-1.020	Health Care Plan		39 MoReg 73	This Issue	
22 CSR 10-2.010	Health Care Plan	39 MoReg 5	39 MoReg 74	This Issue	
22 CSR 10-2.020	Health Care Plan	39 MoReg 7	39 MoReg 75	This Issue	
22 CSR 10-2.030	Health Care Plan	39 MoReg 13	39 MoReg 81	This Issue	
22 CSR 10-2.045	Health Care Plan	39 MoReg 15	39 MoReg 83	This Issue	
22 CSR 10-2.051	Health Care Plan	39 MoReg 16	39 MoReg 84	This Issue	
22 CSR 10-2.052	Health Care Plan	39 MoReg 17	39 MoReg 87	This Issue	
22 CSR 10-2.053	Health Care Plan	39 MoReg 18	39 MoReg 89	This Issue	
22 CSR 10-2.054	Health Care Plan	39 MoReg 20R	39 MoReg 92R	This IssueR	
22 CSR 10-2.055	Health Care Plan	39 MoReg 20R	39 MoReg 92R	This IssueR	
		39 MoReg 21	39 MoReg 92	This Issue	
22 CSR 10-2.060	Health Care Plan	39 MoReg 31	39 MoReg 105	This Issue	
22 CSR 10-2.070	Health Care Plan	39 MoReg 33	39 MoReg 106	This Issue	
22 CSR 10-2.075	Health Care Plan	39 MoReg 34	39 MoReg 107	This Issue	
22 CSR 10-2.089	Health Care Plan	39 MoReg 36	39 MoReg 109	This Issue	
22 CSR 10-2.090	Health Care Plan	39 MoReg 38	39 MoReg 113	This Issue	
22 CSR 10-2.094	Health Care Plan	39 MoReg 767	39 MoReg 783		
22 CSR 10-2.110	Health Care Plan		39 MoReg 115	This Issue	
22 CSR 10-2.130	Health Care Plan	38 MoReg 1359R	38 MoReg 1420R	38 MoReg 2096R	
22 CSR 10-2.140	Health Care Plan	39 MoReg 41	39 MoReg 116	This Issue	
22 CSR 10-3.010	Health Care Plan	39 MoReg 42	39 MoReg 119	This Issue	
22 CSR 10-3.020	Health Care Plan	39 MoReg 42	39 MoReg 119	This Issue	
22 CSR 10-3.045	Health Care Plan	39 MoReg 44	39 MoReg 120	This Issue	
22 CSR 10-3.053	Health Care Plan	39 MoReg 45	39 MoReg 121	This Issue	
22 CSR 10-3.054	Health Care Plan	39 MoReg 46R	39 MoReg 125R	This IssueR	
22 CSR 10-3.055	Health Care Plan	39 MoReg 46	39 MoReg 125	This Issue	
22 CSR 10-3.056	Health Care Plan	39 MoReg 48	39 MoReg 126	This Issue	
22 CSR 10-3.057	Health Care Plan	39 MoReg 48R	39 MoReg 128R	This IssueR	
		39 MoReg 49	39 MoReg 128	This Issue	
22 CSR 10-3.060	Health Care Plan	39 MoReg 59	39 MoReg 141	This Issue	
22 CSR 10-3.075	Health Care Plan	39 MoReg 61	39 MoReg 142	This Issue	
22 CSR 10-3.090	Health Care Plan	39 MoReg 64	39 MoReg 145	This Issue	
22 CSR 10-3.130	Health Care Plan	38 MoReg 1359R	38 MoReg 1423R	38 MoReg 2096R	

# Emergency Rule Table

Agency	Publication	Effective	Expiration
<b>Department of Economic Development</b>			
<b>Division of Business and Community Services</b>			
4 CSR 85-8.011	Definitions . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-8.021	Program Administration . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-9.011	Definitions . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-9.021	Application Process . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-9.031	Project Proposal . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-9.035	Support Contract . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-9.041	Event Notification . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
4 CSR 85-9.051	Cost Certification . . . . .	This Issue . . . . .	April 11, 2014 . . . . . July 30, 2014
<b>Department of Revenue</b>			
<b>Director of Revenue</b>			
12 CSR 10-41.010	Annual Adjusted Rate of Interest . . . . .	38 MoReg 1965 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
<b>Department of Social Services</b>			
<b>MO HealthNet Division</b>			
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates . . . . .	39 MoReg 765 . . . . .	March 1, 2014 . . . . . May 31, 2014
<b>Retirement Systems</b>			
<b>Missouri Local Government Employees' Retirement System (LAGERS)</b>			
16 CSR 20-2.060	Correction of Errors . . . . .	39 MoReg 436 . . . . .	Jan. 2, 2014 . . . . . June 30, 2014
<b>Department of Insurance, Financial Institutions and Professional Registration</b>			
<b>Financial Examination</b>			
20 CSR 200-2.100	Credit for Reinsurance . . . . .	38 MoReg 1695 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
<b>Missouri Consolidated Health Care Plan</b>			
<b>Health Care Plan</b>			
22 CSR 10-2.010	Definitions . . . . .	39 MoReg 5 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.020	General Membership Provisions . . . . .	39 MoReg 6 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.030	Contributions . . . . .	39 MoReg 13 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.045	Plan Utilization Review Policy . . . . .	39 MoReg 15 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.051	PPO 300 Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 16 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.052	PPO 600 Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 17 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.053	High Deductible Health Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 18 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.054	Medicare Supplement Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 20 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 20 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 21 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.060	PPO 300 Plan, PPO 600 Plan, and HDHP Limitations . . . . .	39 MoReg 31 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.070	Coordination of Benefits . . . . .	39 MoReg 33 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.075	Review and Appeals Procedure . . . . .	39 MoReg 34 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.089	Pharmacy Employer Group Waiver Plan for Medicare Primary Members . . . . .	39 MoReg 36 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.090	Pharmacy Benefit Summary . . . . .	39 MoReg 38 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-2.094	Tobacco-Free Incentive Provisions and Limitations . . . . .	39 MoReg 767 . . . . .	May 1, 2014 . . . . . Oct. 27, 2014
22 CSR 10-2.140	Wellness Center Provisions, Charges, and Services . . . . .	39 MoReg 41 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.010	Definitions . . . . .	39 MoReg 42 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.020	General Membership Provisions . . . . .	39 MoReg 42 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.045	Plan Utilization Review Policy . . . . .	39 MoReg 44 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.053	PPO 1000 Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 45 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.054	PPO 2000 Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 46 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.055	High Deductible Health Plan Provisions and Covered Charges . . . . .	39 MoReg 46 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014
22 CSR 10-3.056	PPO 600 Plan Benefit Provisions and Covered Charges . . . . .	39 MoReg 48 . . . . .	Jan. 1, 2014 . . . . . June 29, 2014

<b>Agency</b>		<b>Publication</b>	<b>Effective</b>	<b>Expiration</b>
<b>22 CSR 10-3.057</b>	Medical Plan Benefit Provisions and Covered Charges . . .	.39 MoReg 48 . . . . .	Jan. 1, 2014 . . . . .	June 29, 2014
<b>22 CSR 10-3.057</b>	Medical Plan Benefit Provisions and Covered Charges . . .	.39 MoReg 49 . . . . .	Jan. 1, 2014 . . . . .	June 29, 2014
<b>22 CSR 10-3.060</b>	PPO 600, PPO 1000 Plan, and HDHP Limitations . . . . .	.39 MoReg 59 . . . . .	Jan. 1, 2014 . . . . .	June 29, 2014
<b>22 CSR 10-3.075</b>	Review and Appeals Procedure . . . . .	.39 MoReg 61 . . . . .	Jan. 1, 2014 . . . . .	June 29, 2014
<b>22 CSR 10-3.090</b>	Pharmacy Benefit Summary . . . . .	.39 MoReg 64 . . . . .	Jan. 1, 2014 . . . . .	June 29, 2014



# Executive Orders

Executive Orders	Subject Matter	Filed Date	Publication
<b>2014</b>			
<b>14-04</b>	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	April 3, 2014	Next Issue
<b>14-03</b>	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies.	March 20, 2014	This Issue
<b>14-02</b>	Orders the Honor and Remember Flag be flown at the State Capitol each Armed Forces Day, held on the third Saturday of each May.	March 20, 2014	This Issue
<b>14-01</b>	Creates the Missouri Military Partnership to protect, retain, and enhance the Department of Defense activities in the state of Missouri.	Jan. 10, 2014	39 MoReg 491
<b>2013</b>			
<b>13-14</b>	Orders the Missouri Department of Revenue to follow sections 143.031.1 and 143.091, RSMo, and require all taxpayers who properly file a joint federal income tax return to file a combined state income tax return.	Nov. 14, 2013	38 MoReg 2085
<b>13-13</b>	Advises that state offices will be closed on Friday November 29, 2013.	Nov. 1, 2013	38 MoReg 1859
<b>13-12</b>	Activates the state militia in response to the heavy rains, flooding, and flash flooding that began on Aug. 2, 2013.	Aug. 7, 2013	38 MoReg 1459
<b>13-11</b>	Declares a state of emergency and activates the Missouri State Operation Plan due to heavy rains, flooding, and flash flooding.	Aug. 6, 2013	38 MoReg 1457
<b>13-10</b>	Declares a state of emergency exists in the state of Missouri and directs that the Missouri State Emergency Operations Plan be activated.	May 31, 2013	38 MoReg 1097
<b>13-09</b>	Designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies.	May 3, 2013	38 MoReg 879
<b>13-08</b>	Activates the state militia in response to severe weather that began on April 16, 2013.	April 19, 2013	38 MoReg 823
<b>13-07</b>	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to severe weather that began on April 16, 2013.	April 19, 2013	38 MoReg 821
<b>13-06</b>	Declares a state of emergency and activates the Missouri State Emergency Operations Plan in response to severe weather that began on April 10, 2013.	April 10, 2013	38 MoReg 753
<b>13-05</b>	Declares a state of emergency and directs that the Missouri State Emergency Operations Plan be activated due to severe weather that began on Feb. 20, 2013.	Feb. 21, 2013	38 MoReg 505
<b>13-04</b>	Expresses the commitment of the state of Missouri to the establishment of Western Governors University (WGU) as a non-profit institution of higher education located in Missouri that will provide enhanced access for Missourians to enroll in and complete on-line, competency-based higher education programs. Contemporaneously with this Executive Order, the state of Missouri is entering into a Memorandum of Understanding (MOU) with WGU to further memorialize and establish the partnership between the state of Missouri and WGU.	Feb. 15, 2013	38 MoReg 467
<b>13-03</b>	Orders the transfer of the Division of Energy from the Missouri Department of Natural Resources to the Missouri Department of Economic Development.	Feb. 4, 2013	38 MoReg 465
<b>13-02</b>	Orders the transfer of the post-issuance compliance functions for tax credit and job incentive programs from the Missouri Department of Economic Development to the Missouri Department of Revenue.	Feb. 4, 2013	38 MoReg 463
<b>13-01</b>	Orders the transfer of the Center for Emergency Response and Terrorism from the Department of Health and Senior Services to the Department of Public Safety.	Feb. 4, 2013	38 MoReg 461

The rule number and the MoReg publication date follow each entry to this index.

## ADMINISTRATION, OFFICE OF

state official's salary compensation schedule; 1 CSR 10; 12/2/13

## AGRICULTURE

animal health

inspection of meat and poultry; 2 CSR 30-10.010; 1/2/14, 4/15/14

weights and measures

quality standards for motor fuels; 2 CSR 90-30.040; 7/1/13, 4/15/14

## AIR QUALITY, AIR POLLUTION CONTROL

additional air quality control measures may be required when sources are clustered in a small land area; 10 CSR 10-5.240; 11/15/13

ambient air quality standards; 10 CSR 10-6.010; 12/16/13

control of petroleum liquid storage, loading, and transfer; 10 CSR 10-5.220; 4/1/14

hospital, medical, infection waste incinerators; 10 CSR 10-6.200; 9/3/13, 12/2/13

reference methods; 10 CSR 10-6.040; 4/15/14

restriction of emission of odors; 10 CSR 10-6.165; 3/17/14

## BEHAVIOR ANALYST ADVISORY BOARD

ethical rules of conduct; 20 CSR 2063-6.005; 10/15/13, 3/3/14

## BREATH ALCOHOL IGNITION INTERLOCK DEVICE CERTIFICATION AND OPERATIONAL REQUIREMENTS

approval procedure; 7 CSR 60-2.020; 4/15/13

breath alcohol ignition interlock device security; 7 CSR 60-2.050; 4/15/13

definitions; 7 CSR 60-2.010; 4/15/13

responsibilities of authorized service providers; 7 CSR 60-2.040; 4/15/13

standards and specifications; 7 CSR 60-2.030; 4/15/13

suspension or revocation of approval of a device; 7 CSR 60-2.060; 4/15/13

## BUSINESS AND COMMUNITY SERVICES, DIVISION OF

application process

4 CSR 85-9.021; 3/3/14, 5/1/14

4 CSR 85-10.030; 3/17/14

completion and closing; 4 CSR 85-10.040; 3/17/14

cost certification; 4 CSR 85-9.051; 3/3/14, 5/1/14

definitions

4 CSR 85-8.011; 3/3/14, 5/1/14

4 CSR 85-9.011; 3/3/14, 5/1/14

event notification

4 CSR 85-9.041; 3/3/14, 5/1/14

general organization; 4 CSR 85-10.010; 3/17/14

miscellaneous; 4 CSR 85-10.060; 3/17/14

model procurement standards; 4 CSR 85-10.050; 3/17/14

project proposal

4 CSR 85-9.031; 3/3/14, 5/1/14

program administration

4 CSR 85-8.021; 3/3/14, 5/1/14

remediation tax credits; 4 CSR 85-10.020; 3/17/14

support contract; 4 CSR 85-9.035; 3/3/14, 5/1/14

## CERTIFICATE OF NEED PROGRAM

application package; 19 CSR 60-50.430; 4/15/14

application review schedule; 19 CSR 60-50; 3/17/14

certificate of need decisions; 19 CSR 60-50.600; 4/15/14

criteria and standards for equipment and new hospitals; 19 CSR 60-50.440; 4/15/14

criteria and standards for long-term care; 19 CSR 60-50.450; 4/15/14

letter of intent package; 19 CSR 60-50.410; 4/15/14

letter of intent process; 19 CSR 60-50.400; 4/15/14

post-decision activity; 19 CSR 60-50.700; 4/15/14

review process; 19 CSR 60-50.420; 4/15/14

special exemption subcommittee; 19 CSR 60-50.415; 4/15/14

## CHILDREN'S DIVISION

alternative care review board; 13 CSR 35-36.010; 12/2/13, 3/17/14

basic residential treatment for children and youth core requirements (applicable to all agencies)—basis for licensure and licensing procedures; 13 CSR 35-71.020; 1/15/14

buildings, grounds, and equipment; 13 CSR 35-71.080; 1/15/14

child care program; 13 CSR 35-71.110; 1/15/14

court review and dispositional hearing; 13 CSR 35-71.030; 1/15/14

definitions; 13 CSR 35-71.010; 1/15/14

exemptions of religious residential treatment for children and youth operating sites; 13 CSR 35-71.025; 1/15/14

hand-up pilot program; 13 CSR 35-32.040; 6/3/13, 10/1/13

health care; 13 CSR 35-71.075; 1/15/14

hearings and judicial review; 13 CSR 35-71.035; 1/15/14

organization and administration; 13 CSR 35-71.040; 1/15/14

personnel; 13 CSR 35-71.045; 1/15/14

protection and care of the child; 13 CSR 35-71.070; 1/15/14

record keeping; 13 CSR 35-71.090; 1/15/14

social services program; 13 CSR 35-71.060; 1/15/14

specialized standards for intensive residential treatment for children and youth; 13 CSR 35-71.140; 1/15/14

specialized standards—residential treatment for children and youth; 13 CSR 35-71.130; 1/15/14

specific rules for basic care agencies providing care for infant, toddler, or preschool age children (birth through age six); 13 CSR 35-71.100; 1/15/14

specific rules for residential treatment agencies for children and youth providing maternity care; 13 CSR 35-71.120; 1/15/14

staff qualifications and requirements; 13 CSR 35-71.050; 1/15/14

## CLEAN WATER COMMISSION

fees; 10 CSR 20-6.011; 10/1/13, 4/15/14

## CONSERVATION, DEPARTMENT OF

closing; 3 CSR 10-11.115; 4/15/14

endangered species; 3 CSR 10-4.111; 4/15/14

fishing

daily and possession limits

3 CSR 10-11.210; 4/15/14

3 CSR 10-12.140; 4/15/14, 4/15/14

length limits

3 CSR 10-11.215; 4/15/14

3 CSR 10-12.145; 4/15/14, 4/15/14

methods and limits; 3 CSR 10-11.205; 4/15/14

other fish; 3 CSR 10-6.550; 4/15/14

sale of live bait; 3 CSR 10-10.735; 4/15/14

use of boats and motors; 3 CSR 10-12.110; 4/15/14

## COSMETOLOGY AND BARBER EXAMINERS, BOARD OF

instructor renewal and inactive license requirements; 20 CSR 2085-8.070; 1/2/14

## DEAF AND HARD OF HEARING, MISSOURI COMMISSION FOR THE

application for interpreter in Missouri; 5 CSR 100-200.050; 3/3/14

certification maintenance; 5 CSR 100-200.130; 3/3/14

fees; 5 CSR 100-200.150; 3/3/14

general organization; 5 CSR 100-200.010; 3/3/14

Missouri interpreters certification system

5 CSR 100-200.030; 3/3/14  
5 CSR 100-200.035; 3/3/14  
performance test and evaluation; 5 CSR 100-200.070; 3/3/14  
provisional certification in education; 5 CSR 100-200.045; 3/3/14  
reinstatement; 5 CSR 100-200.210; 3/3/14  
restricted certification in education; 5 CSR 100-200.040; 3/3/14  
skill level standards; 5 CSR 100-200.170; 3/3/14  
voluntary recertification; 5 CSR 100-200.075; 3/3/14  
written test; 5 CSR 100-200.060; 3/3/14

#### **ELEMENTARY AND SECONDARY EDUCATION, DEPARTMENT OF**

administrative appeal procedure for applicants denied certification;  
5 CSR 20-400.120; 1/15/14  
administrative procedures for recertifying teachers whose certificates have been revoked by a certifying authority other than the state board of education; 5 CSR 20-400.140; 1/15/14  
administrative procedures for recertifying teachers whose certificates have been revoked by the state board of education;  
5 CSR 20-400.130; 1/15/14  
appeals; 5 CSR 20-500.170; 3/3/14  
application for certificate of license to teach; 5 CSR 20-400.500; 12/2/13, 4/1/14  
certification requirements for teacher of  
adult education and literacy; 5 CSR 20-400.700; 12/2/13, 4/1/14  
career continuous administrator certificate; 5 CSR 20-400.630; 12/2/13, 4/1/14  
career continuous career education certificate; 5 CSR 20-400.690; 12/2/13, 4/1/14  
career continuous student services certificate; 5 CSR 20-400.650; 12/2/13, 4/1/14  
career education (postsecondary) certificates; 5 CSR 20-400.670; 12/2/13, 4/1/14  
career education (secondary) certificates; 5 CSR 20-400.660; 12/2/13, 4/1/14  
career education (secondary/postsecondary) certificates; 5 CSR 20-400.680; 12/2/13, 4/1/14  
early childhood education (birth-pre-kindergarten); 5 CSR 20-400.510; 12/2/13, 4/1/14  
elementary education (grades K-6); 5 CSR 20-400.520; 12/2/13, 4/1/14  
English for speakers of other languages (grades K-12); 5 CSR 20-400.570; 12/2/13, 4/1/14  
gifted education (grades K-12); 5 CSR 20-400.580; 12/2/13, 4/1/14  
initial administrator certificate; 5 CSR 20-400.610; 12/2/13, 4/1/14  
initial student services certificate; 5 CSR 20-400.640; 12/2/13, 4/1/14  
K-12 education; 5 CSR 20-400.550; 12/2/13, 4/1/14  
mathematics specialists (grades 1-6); 5 CSR 20-400.590; 12/2/13, 4/1/14  
middle school education (grades 5-9); 5 CSR 20-400.530; 12/2/13, 4/1/14  
secondary education (grades 9-12); 5 CSR 20-400.540; 12/2/13, 4/1/14  
special education; 5 CSR 20-400.560; 12/2/13, 4/1/14  
special reading (grades K-12); 5 CSR 20-400.600; 12/2/13, 4/1/14  
transition administrator certificate; 5 CSR 20-400.620; 12/2/13, 4/1/14  
charter school closure; 5 CSR 20-100.265; 11/1/13, 4/1/14  
confidentiality and release of information; 5 CSR 20-500.130; 3/3/14  
definitions; 5 CSR 20-500.120; 11/1/13, 4/1/14  
districts effectively evaluating educators; 5 CSR 20-400.375; 12/2/13, 3/17/14

due process hearing; 5 CSR 20-500.190; 3/3/14  
eligibility; 5 CSR 20-500.150; 3/3/14  
eligibility for scholarships; 5 CSR 10-2.030; 12/2/13, 4/1/14  
informal review; 5 CSR 20-500.180; 3/3/14  
mediation; 5 CSR 20-500.200; 3/3/14  
minimum standards; 5 CSR 20-500.140; 3/3/14  
Missouri school improvement program; 5 CSR 20-100.170; 12/2/13, 5/1/14  
order of selection for services; 5 CSR 20-500.160; 3/3/14  
physical fitness challenge/assessment "Cade's Law"; 5 CSR 20-200.290; 11/1/13, 4/1/14  
scholarship granting organizations; 5 CSR 10-2.010; 12/2/13, 4/1/14  
scholarships; 5 CSR 10-2.020; 12/2/13, 4/1/14  
training of school employees in the care needed for students with diabetes; 5 CSR 20-200.300; 11/1/13, 4/1/14

#### **ENERGY, DIVISION OF**

definitions and general provisions; 10 CSR 140-5.010; 7/1/13, 10/15/13

#### **EXECUTIVE ORDERS**

designates members of the governor's staff to have supervisory authority over certain departments, divisions, and agencies; 14-03; 5/1/14  
orders the honor and remember flag be flown at the state capitol each armed forces day, held on the third Saturday of each May; 14-02; 5/1/14

#### **FAMILY SUPPORT DIVISION**

community programs  
formula for the distribution of community service block grant funds to community action agencies; 13 CSR 40-24.080; 12/2/13, 5/1/14  
supplemental funding formula for community action agencies to administer the CSBG program; 13 CSR 40-24.090; 12/2/13, 5/1/14  
use of community service block grant discretionary funds; 13 CSR 40-24.100; 12/2/13, 5/1/14

#### **FINANCE, DIVISION OF**

operations and supervision of residential mortgage loan brokers; 20 CSR 1140-30.240; 10/15/13, 3/17/14

#### **GAMING COMMISSION, MISSOURI**

access to areas of class B licensee facilities; 11 CSR 45-7.170; 1/15/14  
affiliate supplier's license; 11 CSR 45-4.205; 1/15/14  
application for class A or class B license; 11 CSR 45-4.030; 1/15/14  
application period and fees for a class A and class B license; 11 CSR 45-4.055 1/15/14  
definitions; 11 CSR 45-1.090; 3/3/14  
identification badge requirements; 11 CSR 45-4.410; 1/15/14  
licensee performance of duties; 11 CSR 45-4.400; 1/15/14  
licensee's and applicant's duty to disclose changes in information; 11 CSR 45-10.020; 1/15/14  
license renewal and continuing suitability requirement; 11 CSR 45-4.190; 1/15/14  
licenses, restrictions on licenses, licensing authority for the executive director, and other definitions; 11 CSR 45-4.020; 1/15/14  
minimum internal control standards (MICS)  
chapter K; 11 CSR 45-9.111; 12/2/13, 5/1/14  
chapter M; 11 CSR 45-9.113; 1/15/14  
chapter R; 11 CSR 45-9.118; 1/15/14  
chapter S; 11 CSR 45-9.119; 12/2/13, 5/1/14  
minimum standards for electronic gaming devices; 11 CSR 45-5.190; 3/3/14  
occupational and key person/key business entity license application and annual fees; 11 CSR 45-4.380; 1/15/14  
occupational license; 11 CSR 45-4.420; 1/15/14

occupational license renewal; 11 CSR 45-4.390; 1/15/14  
 occupational licenses for class A, class B, and suppliers; 11 CSR 45-4.260; 1/15/14  
 requests for gaming devices and associated equipment approval; 11 CSR 45-5.225; 3/3/14  
 requests for hearings; 11 CSR 45-13.030; 1/15/14  
 types of licenses; 11 CSR 45-4.010; 1/15/14  
 shipping of electronic gaming devices, gaming equipment, or supplies; 11 CSR 45-5.237; 12/2/13, 5/1/14  
 supplier's license; 11 CSR 45-4.200; 1/15/14  
 supplier's license criteria; 11 CSR 45-4.230; 3/3/14

## HEALTH AND SENIOR SERVICES

director, office of the  
     reporting patient abstract data by hospitals and ambulatory surgical centers; 19 CSR 10-33.010; 3/17/14  
 regulation and licensure  
     administrative standards for rehabilitation hospitals; 19 CSR 30-22.020; 2/3/14  
     central services; 19 CSR 30-20.088; 2/3/14  
     fire safety, general safety, and operating features; 19 CSR 30-20.108; 2/3/14  
     food and nutrition services; 19 CSR 30-20.090; 2/3/14  
     infection prevention and control; 19 CSR 30-20.116; 2/3/14  
     medical records; 19 CSR 30-20.094; 2/3/14  
     nursing services; 19 CSR 30-20.096; 2/3/14  
     registration as a hospital infectious waste generator; 19 CSR 30-20.070; 2/3/14  
     respiratory care services; 19 CSR 30-20.136; 2/3/14  
     social services; 19 CSR 30-20.104; 2/3/14  
     specialized inpatient care services; 19 CSR 30-20.138; 2/3/14  
     standards for registration as a hospital infectious waste generator  
         19 CSR 30-22.030; 2/3/14  
         19 CSR 30-24.040; 2/3/14  
     surgical services; 19 CSR 30-20.140; 2/3/14  
     unlicensed assistive personnel training program; 19 CSR 30-20.125; 2/3/14  
 skill performance evaluation certificates for commercial drivers; 7 CSR 10-25.010; 3/3/14

## HIGHWAYS AND TRANSPORTATION COMMISSION, MISSOURI

organization; general provisions  
     description, organization, and information; 7 CSR 10-1.010; 3/17/14  
 outdoor advertising  
     administrative review of notices to remove outdoor advertising and to terminate nonconforming signs; 7 CSR 10-6.090; 11/15/13, 4/15/14  
     cutting and trimming of vegetation on right-of-way; 7 CSR 10-6.085; 11/15/13, 4/15/14  
     definitions; 7 CSR 10-6.015; 11/15/13, 4/15/14  
     directional and other official signs; 7 CSR 10-6.020; 11/15/13, 4/15/14  
     nonconforming signs; 7 CSR 10-6.060; 11/15/13, 4/15/14  
     on-premises signs; 7 CSR 10-6.030; 11/15/13, 4/15/14  
 outdoor advertising  
     beyond six hundred sixty feet of the right-of-way; 7 CSR 10-6.050; 11/15/13, 4/15/14  
     in zoned and unzoned commercial and industrial areas; 7 CSR 10-6.040; 11/15/13, 4/15/14  
     permits for outdoor advertising; 7 CSR 10-6.070; 11/15/13, 4/15/14  
     public information; 7 CSR 10-6.010; 11/15/13, 4/15/14  
     removal of outdoor advertising without compensation; 7 CSR 10-6.080; 11/15/13, 4/15/14  
 scenic byways  
     application procedures; 7 CSR 10-12.020; 2/18/14  
     nomination review process; 7 CSR 10-12.030; 2/18/14  
     scenic byways; 7 CSR 10-12.010; 2/18/14

## INSURANCE

applied behavior analysis maximum benefit; 20 CSR; 3/3/14  
 construction claims binding arbitration cap; 20 CSR; 1/2/14  
 Missouri life and health insurance guaranty association; 20 CSR 400-5.600; 11/15/13, 3/3/14  
 sovereign immunity limits; 20 CSR; 1/2/14  
 state legal expense fund; 20 CSR; 1/2/14

## LABOR AND INDUSTRIAL RELATIONS, DEPARTMENT OF

employment security  
     appeals to an appeals tribunal; 8 CSR 10-5.010; 7/1/13, 10/15/13  
     charging of benefits to reimbursable employers; 8 CSR 10-3.085; 11/15/13, 3/3/14  
 workers' compensation  
     resolution of medical fee disputes; 8 CSR 50-2.030; 12/16/13, 4/15/14

## MEDICAID AUDIT AND COMPLIANCE, MISSOURI

definitions; 13 CSR 65-2.010; 1/15/14  
 denial or limitations of applying provider; 13 CSR 65-2.030; 1/15/14  
 provider enrollment and application; 13 CSR 65-2.020; 1/15/14

## MENTAL HEALTH, DEPARTMENT OF

designation of programs to receive county community mental health funds; 9 CSR 30-2.010; 2/3/14

## MISSOURI CONSOLIDATED HEALTH CARE PLAN

contributions; 22 CSR 10-2.030; 1/2/14, 5/1/14  
 coordination of benefits; 22 CSR 10-2.070; 1/2/14, 5/1/14  
 definitions  
     22 CSR 10-2.010; 1/2/14, 5/1/14  
     22 CSR 10-3.010; 1/2/14, 5/1/14  
 general foster parent membership provisions; 22 CSR 10-2.110; 1/2/14, 5/1/14  
 general membership provisions  
     22 CSR 10-2.020; 1/2/14, 5/1/14  
     22 CSR 10-3.020; 1/2/14, 5/1/14  
 general organization; 22 CSR 10-1.010; 1/2/14, 5/1/14  
 limitations  
     PPO 300 plan, PPO 600 plan, and HDHP; 22 CSR 10-2.060; 1/2/14, 5/1/14  
     PPO 600 Plan, PPO 1000 Plan, and HDHP; 22 CSR 10-3.060; 1/2/14, 5/1/14  
 pharmacy benefit summary  
     22 CSR 10-2.090; 1/2/14, 5/1/14  
     22 CSR 10-3.090; 1/2/14, 5/1/14  
 pharmacy employer group waiver plan for medicare primary members; 22 CSR 10-2.089; 1/2/14, 5/1/14  
 plan benefit provisions and covered charges  
     high deductible health plan  
         22 CSR 10-2.053; 1/2/14, 5/1/14  
         22 CSR 10-3.055; 1/2/14, 5/1/14  
     medicare supplement; 22 CSR 10-2.054; 1/2/14, 5/1/14  
     medical  
         22 CSR 10-2.055; 1/2/14, 5/1/14  
         22 CSR 10-3.057; 1/2/14, 5/1/14  
     PPO 300; 22 CSR 10-2.051; 1/2/14, 5/1/14  
     PPO 600  
         22 CSR 10-2.052; 1/2/14, 5/1/14  
         22 CSR 10-3.056; 1/2/14, 5/1/14  
     PPO 1000; 22 CSR 10-3.053; 1/2/14, 5/1/14  
     PPO 2000; 22 CSR 10-3.054; 1/2/14, 5/1/14

plan utilization review policy  
22 CSR 10-2.045; 1/2/14, 5/1/14  
22 CSR 10-3.045; 1/2/14, 5/1/14  
public records; 22 CSR 10-1.020; 1/2/14, 5/1/14  
review and appeals procedure  
22 CSR 10-2.075; 1/2/14, 5/1/14  
22 CSR 10-3.075; 1/2/14, 5/1/14  
tobacco-free incentive provisions and limitations; 22 CSR 10-2.094;  
4/1/14  
wellness center provisions, charges, and services; 22 CSR 10-  
2.140; 1/2/14, 5/1/14

#### **MO HEALTHNET**

ambulance service reimbursement allowance; 13 CSR 70-3.200;  
11/15/13, 3/17/14  
global per diem adjustments to nursing facility and HIV nursing  
facility reimbursement rates; 13 CSR 70-10.016; 12/2/13,  
4/1/14, 4/1/14  
hearing aid program; 13 CSR 70-45.010; 11/15/13, 3/17/14  
MO HealthNet (Medicaid) payment for certain services furnished  
by certain physicians in calendar years 2013 and 2014; 13  
CSR 70-25.120; 11/15/13, 3/17/14  
MO HealthNet program benefits for human organ and bone mar-  
row/stem cell transplants and related medical services; 13  
CSR 70-2.200; 4/15/14  
optical benefits and limitations—MO HealthNet Program; 13 CSR  
70-40.010; 11/15/13, 3/17/14  
payment policy for early elective delivery; 13 CSR 70-3.250;  
4/15/14  
prior authorization process for non-pharmaceutical behavioral  
health services; 13 CSR 70-98.020; 11/15/13, 3/3/14  
prospective reimbursement plan for nonstate-operated facilities for  
ICF/MR services; 13 CSR 70-10.030; 1/15/14, 5/1/14  
sanctions for false or fraudulent claims for MO HealthNet services;  
13 CSR 70-3.030; 10/15/13, 3/3/14  
standards for privacy of individually identifiable health information;  
13 CSR 70-1.020; 4/15/14

#### **OPTOMETRY, STATE BOARD OF**

license renewal; 20 CSR 2210-2.030; 1/2/14, 4/15/14

#### **PROBATION AND PAROLE, STATE BOARD OF**

definitions for intervention fees; 14 CSR 80-5.010; 12/2/13,  
3/17/14  
intervention fee procedure; 14 CSR 80-5.020; 12/2/13, 3/17/14

#### **PROFESSIONAL REGISTRATION, DIVISION OF**

designation of license renewal dates and related renewal informa-  
tion; 20 CSR 2231-2.010; 2/18/14

#### **PUBLIC SERVICE COMMISSION**

discovery and prehearings; 4 CSR 240-2.090; 3/3/14  
filing and reporting requirements  
requirements for carrier designation as eligible telecommuni-  
cations carriers; 4 CSR 240-3.570; 9/16/13, 3/3/14  
universal service  
applications for MoUSF funds; 4 CSR 240-31.080; 9/16/13,  
3/3/14  
collection of MoUSF surcharge from end-user subscribers; 4  
CSR 240-31.065; 9/16/13, 3/3/14  
definitions; 4 CSR 240-31.010; 9/16/13, 3/3/14  
disbursements of MoUSF funds; 4 CSR 240-31.090; 9/16/13,  
3/3/14  
eligibility for funding  
low-income customers and disabled customers; 4 CSR  
240-31.050; 9/16/13, 3/3/14  
high cost areas; 4 CSR 240-31.040; 9/16/13, 3/3/14

eligible telecommunications carrier requirements; 4 CSR 240-  
31.130; 9/16/13, 3/3/14  
lifeline program and disabled program; 4 CSR 240-31.120;  
9/16/13, 3/3/14  
MoUSF assessment; 4 CSR 240-31.060; 9/16/13, 3/3/14  
MoUSFA; 4 CSR 240-31.030; 9/16/13, 3/3/14  
organization, powers, and meetings of the board; 4 CSR 240-  
31.020; 9/16/13, 3/3/14  
receipt of MoUSF funds; 4 CSR 240-31.070; 9/16/13, 3/3/14  
review of board and MoUSFA activities; 4 CSR 240-31.110;  
9/16/13, 3/3/14  
review procedures for support payments; 4 CSR 240-31.100;  
9/16/13, 3/3/14

#### **RETIREMENT SYSTEMS**

Missouri local government employees' retirement system  
(LAGERS)  
correction of errors; 16 CSR 20-2.060; 2/3/14  
public school retirement system of Missouri, the  
payment of funds to the retirement system; 16 CSR 10-3.010;  
2/18/14  
source of funds; 16 CSR 10-6.020; 2/18/14

#### **SECURITIES**

application for registration; 15 CSR 30-52.015; 1/15/14  
definitions; 15 CSR 30-50.010; 1/15/14  
forms; 15 CSR 30-50.040; 1/15/14  
general; 15 CSR 30-54.010; 1/15/14  
NASAA statement of policy; 15 CSR 30-52.030; 1/15/14  
not-for-profit securities; 15 CSR 30-54.070; 1/15/14  
small company offering registration (formerly Missouri issuer reg-  
istration); 15 CSR 30-52.275; 1/15/14  
suggested form of investment letter; 15 CSR 30-54.150; 1/15/14

#### **TAX**

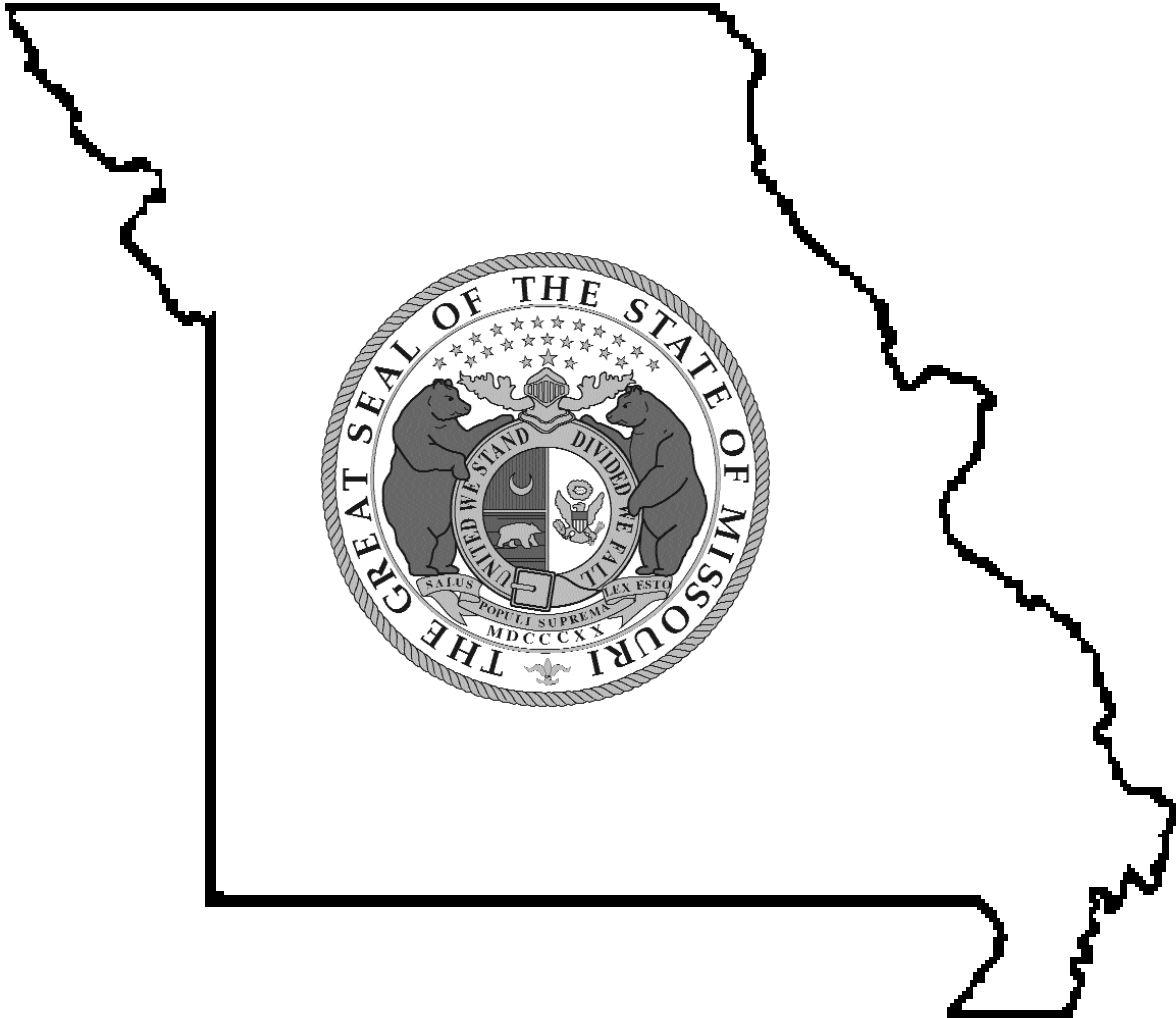
annual adjusted rate of interest; 12 CSR 10-41.010; 12/2/13, 3/3/14  
new apportionment method; 12 CSR 10-2.052; 11/1/13, 2/3/14  
taxation of software; 12 CSR 10-109.050; 2/18/14

#### **TAX COMMISSION, STATE**

agricultural land productive values; 12 CSR 30-4.010; 2/3/14

# RULEMAKING 1-2-3

## DRAFTING AND STYLE MANUAL



JASON KANDER  
SECRETARY OF STATE

The Administrative Rules Division has copies of the Rulemaking Manual available for state agencies to assist in preparing all types of rulemakings.

For information about rule drafting classes call (573) 751-4015.

# To Subscribe to the *Missouri Register*

SALUS POPULI SUPREMA LEX ESTO

*"The welfare of the people shall be the  
supreme law."*



JASON KANDER

SECRETARY OF STATE

MISSOURI  
REGISTER

Contact us at: phone: (573) 751-4015 or email: [rules@sos.mo.gov](mailto:rules@sos.mo.gov)

## ORDER FORM

- ☐ Enclosed is my check for \$56 as payment in advance for one year of the *Missouri Register*

Please start my subscription with the \_\_\_\_\_ issue.

Please make checks payable to: **Secretary of State** or alternatively call us to charge your credit card.

Mail to: JASON KANDER  
SECRETARY OF STATE  
ADMINISTRATIVE RULES DIVISION  
PO Box 1767  
JEFFERSON CITY, MO 65102

\_\_\_\_\_  
Name or Firm (Please Type or Print)

\_\_\_\_\_  
Attn:

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

### **Administrative Rules Contact Information**

**General Inquiries**

(573) 751-4015  
rules@sos.mo.gov

**Waylene Hiles, Director**

(573) 751-1869  
waylene.hiles@sos.mo.gov

**Curtis W. Treat, Managing Editor**

(573) 751-2022  
curtis.treat@sos.mo.gov

**Amanda McKay, Editor**

(573) 522-2593  
amanda.mckay@sos.mo.gov

**Vonne Kilbourn, Assistant Editor**

(573) 751-1818  
vonne.kilbourn@sos.mo.gov

**Marty Spann, Assistant Editor**

(573) 522-2196  
martha.spann@sos.mo.gov

**Jacqueline D. White, Publications**

(573) 526-1259  
jacqueline.white@sos.mo.gov

**Alisha Dudenhoeffer, Administrative Assistant**

(573) 751-4015  
alisha.dudenhoeffer@sos.mo.gov